MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Edward P. Kamps

Director, Program Policy Division
Bureau of Medicaid Policy and Actuarial Services

Project Number:	0420-NF	**Comments Due:**	July 29, 2004	**Proposed Effective Date:**	October 1, 2004

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Policy Subject: Michigan Medicaid Long Term Care Admission Requirements

Affected Programs: Medicaid

Distribution: Nursing Facilities, Hospitals, Practitioners, Hospices, Community Mental Health Services Programs, MI Choice, PACE

Summary: The Michigan Department of Community Health (MDCH) is implementing revised functional/ medical eligibility criteria for long term care services reimbursed by Medicaid. Federal regulations require that Medicaid pay only for services for those beneficiaries who meet specified level of care criteria, and for nursing facilities, Pre-Admission Screening/Annual Resident Review requirements. This bulletin provides the revised functional/medical criteria and outlines the admission process requirements for Medicaid-reimbursed nursing facility, MI Choice, and PACE programs.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Practitioners (Provider Type 10)
Hospice (Provider Type 15)
Medicaid Health Plans (Provider Type 17)
Hospitals (Provider Type 30, 40)
Nursing Home Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Intermediate Care Facility for the Mentally Retarded (ICF/MR) (Provider Type 65)
Other [Specialized out-of-state facilities] (Provider Type 71)
Nursing Facilities for the Mentally Ill (Provider Type 72)
Community Mental Health Services Programs
Home and Community-Based Services for the Elderly and Disabled (MI Choice) Waiver
Program for All-Inclusive Care for the Elderly (PACE)

Issued: September 1, 2004 (Proposed)

Subject: Admission Requirements for Medicaid Nursing Facilities, MI Choice Program, and PACE Program

Effective: October 1, 2004 (Proposed)

Programs Affected: Medicaid

The Michigan Department of Community Health (MDCH) is implementing revised functional/medical eligibility criteria for Medicaid nursing facility, MI Choice, and PACE services. Federal regulations require that Medicaid pay only for services for those beneficiaries who meet specified level of care criteria. Nursing facility residents must also meet Pre-Admission Screening/Annual Resident Review requirements. This bulletin provides the revised functional/medical criteria and outlines the admission process requirements for Medicaid-reimbursed nursing facility, MI Choice, and PACE services.

The revised criteria (Attachment A - Michigan Medicaid Nursing Facility Level of Care Determination) apply to all Medicaid-reimbursed admissions to nursing facilities (or at initiation of Medicaid benefits), or enrollments in MI Choice or PACE, on and after October 1, 2004. All Medicaid beneficiaries that reside in a nursing facility on October 1, 2004 must undergo the evaluation process by the date of their annual re-certification. MI Choice and PACE enrollees must also undergo the evaluation process by the date of their annual re-certification.

Nursing facilities, MI Choice, and PACE have multiple components for determining eligibility for services. Attachments 1-3 explain the components that comprise the eligibility and admission processes specific to each program. Attachments A-G are the tools utilized in these processes and apply to all three programs.

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NURSING FACILITY ELIGIBILITY AND ADMISSION PROCESS

The following proposed changes would replace current policy published in the Section 4 of the Nursing Facility Chapter III (Coverages and Limitations).

SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

4.1 Nursing Facility Eligibility

There are five necessary components for determining eligibility for Medicaid nursing facility reimbursement.

4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility by the Family Independence Agency (FIA). When a Medicaid-eligible or potentially eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565C) to the local FIA office to establish/confirm eligibility for Medicaid benefits. (Refer to the Forms Appendix of the Medicaid Provider Manual for a sample form.)

A facility is considered to be officially notified of a beneficiary's Medicaid eligibility when they have received the completed MSA 2565-C, Facility Admissions Notice.

In order for Medicaid to reimburse nursing facility services, the beneficiary must be in a Medicaid-certified bed.

4.1.B. Correct/Timely Pre-admission Screening/Annual Resident Review (PASARR)

The Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Pre-admission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form (DCH-3877) may be found at the MDCH web site. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the level I screening was performed and that the Level II screening was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

4.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

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With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

4.1.D. Appropriate Placement Based on Medicaid Nursing Facility Level of Care Determination

4.1.D.1 Michigan Medicaid Nursing Facility Level of Care Determination Tool and Use

The nursing facility must verify beneficiary appropriateness for nursing facility services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination form that can be found at (www.Michigan.gov/mdch). The nursing facility may not bill Medicaid for services provided when the beneficiary does not meet the established criteria identified through the tool or NF LOC Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Claims for service dates prior to the electronic tool determination date will not be reimbursed by Medicaid. In addition, services will not be reimbursed when the determination does not demonstrate functional/medical eligibility through the electronic web-based tool.

A copy of the Michigan Medicaid Nursing Facility Level of Care Determination form and Field Definitions are attached (see Attachments A and B). When finalized, these documents will be posted on the MDCH website at www.michigan.gov/mdch.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. The nursing facility will be held responsible for billing Medicaid for only those residents who meet the criteria outlined in this bulletin.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool for:

- **all new admissions of Medicaid-eligible beneficiaries**, regardless of primary payer source, if Medicaid reimbursement beyond Medicare co-insurance and deductible amounts will be requested
- **readmissions of Medicaid-eligible beneficiaries** after more than ten calendar days continuous absence from the nursing facility, if Medicaid reimbursement beyond Medicare coinsurance and deductible amounts will be requested
- **non-emergency transfers of Medicaid-eligible beneficiaries to** another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure
- **disenrollment of a beneficiary from a Medicaid Health Plan** which has been paying for nursing facility services
- **private-pay residents already residing in a nursing facility** who are applying for Medicaid as the payer for nursing facility services
- **hospice-eligible beneficiaries who are being admitted** to the nursing facility for end-of-life care

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Completion of the Determination Tool is not required in the following situations:

- **any transfer of a Medicaid-eligible beneficiary from a nursing facility that is undergoing an involuntary facility closure due to Federal or State regulatory enforcement action**; situations for retrospective review of transferred residents will still apply

- **emergency transfer of a Medicaid-eligible beneficiary** from a nursing facility experiencing a hazardous condition (e.g., fire, flood, loss of heat) that could cause harm to residents, when such transfers have been approved by the State Survey Agency

- **readmission of a Medicaid-eligible beneficiary** to the same nursing facility within ten calendar days of a transfer for emergency inpatient hospitalization

- **hospice eligible beneficiaries who are being admitted** to the nursing facility for respite services

Process Guidelines define required process steps for use of the electronic web-based form and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are attached (see Attachment C). When finalized the guidelines will be available on the MDCH website at www.michigan.gov/mdch.

The revised functional/medical criteria include seven domains of need:
- Activities of Daily Living,
- Cognition,
- Physician Involvement,
- Treatments and Conditions,
- Skilled Therapies,
- Behavior, and
- Service Dependency.

For residents who qualify under only three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The electronic web-based tool must be completed only once for each admission or readmission.

4.1.D.2 Nursing Facility Level of Care Exception Process (NF LOC Exception Process)
An exception process is available for those applicants who have demonstrated a significant level of long term care need, but do not meet the Michigan Medicaid Nursing Facility Level of Care criteria. The NF LOC Exception Process is initiated when the prospective provider telephones MDCH or its designee and requests review after the applicant has been determined ineligible using the web-based electronic tool. The NF LOC Exception Criteria is attached (see Attachment D). When finalized, this information will be available on the MDCH website at www.michigan.gov/mdch. To request an NF LOC Exception review, providers may call xxx-xxx-xxxx.

4.1.D.3 Telephone Intake Guidelines
The Telephone Intake Guidelines are a list of questions that identify potential nursing facility residents. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the nursing facility. A copy of the guidelines is attached (see Attachment E). When finalized, this document will be available on the MDCH website at www.Michigan.gov/mdch.

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4.1.D.4 Annual Re-certification

Nursing facility residents must undergo annual re-certification to establish that they continue to meet functional/medical eligibility requirements; however, Medicaid residents must also meet the nursing facility level of care definition on an ongoing basis for services to be reimbursed. Quarterly Minimum Data Set assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis. MDCH suggests that the annual re-certification review coincide with the Annual Resident Review required under the Michigan PASARR policy.

All Medicaid nursing facility residents as of October 1, 2004, must be assessed using the electronic web-based eligibility tool at the time of the next annual re-certification review. Residents who have resided in a facility for 12 months or longer must be offered the opportunity and assistance to transition to the community, but may not be required to do so. If the nursing facility determines that the resident who has been in the facility for less than 12 months is not eligible for services based on functional/medical criteria, the resident must be provided an adverse action notice and referred to appropriate service programs.

4.1.D.5 Retrospective Review and Medicaid Recovery

At random and whenever indicated, MDCH will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination and the quality of Medicaid MDS data overall. If the resident is found to be ineligible for nursing facility services, MDCH will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

4.1.D.6 Adverse Action Notice

When the provider determines that the applicant or current resident does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the provider must issue an adverse action notice to the applicant or their authorized representative. The provider must also offer the applicant referral information about services that may help meet their needs. The action notice must include all of the language of the sample letters for long term care (in development).

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedures Manual explain the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information for the Administrative Tribunal.)

Immediate Review-Adverse Action Notices

MDCH or its designee will review all pre-admission or continued stay adverse action notices upon request by a Medicaid beneficiary or representative. When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- MDCH or its designee will request that the nursing facility provide pertinent information by close of business of the first working day after the date of the beneficiary (or representative) receives the notice.

- MDCH or its designee will review the records, obtain information from the beneficiary or beneficiary representative, and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

The beneficiary (or authorized representative) may still request an MDCH appeal of the Level of Care Determination.

Beneficiaries may call xxx-xxx-xxxx to request an appeal.

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4.1.E Freedom of Choice

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect, in writing, to receive services in a specific program. This election must take place prior to initiating nursing facility services under Medicaid.

The applicant, or legal representative, must be informed of the following:

- services available under the nursing facility program
- services available in a community setting, including those available through the MI Choice Program, or PACE program

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to State Services for Person with Long Term Care Needs (see Attachment F). When finalized, the guidelines will be available on the MDCH website at www.michigan.gov/mdch. Applicants who prefer a community long-term care option, but are admitted to a nursing facility because of unavailable slots or other considerations must also have an active discharge plan documented for at least the first year of care.

Applicants must indicate their choice of program in writing by signing the Freedom of Choice form. A completed copy of this form for nonadmissions must be retained for a period of three years. The completed form must be kept in the medical record if the resident chooses admission to a nursing facility. The Freedom of Choice form must also be witnessed by an applicant representative.

A copy of this form is included with the Michigan Medicaid Nursing Facility Level of Care Determination (Attachment A). When finalized, this document will be available on the MDCH website at www.michigan.gov/mdch.

4.2 APPEALS

4.2.A. Individual Appeals

Financial Eligibility: A determination that an applicant is not eligible for Medicaid is an adverse action. Applicants may appeal such an action to the Family Independence Agency (FIA).

Functional/Medical Eligibility: A determination that an applicant is not **functionally/medically eligible for nursing facility services** is an adverse action. If the applicant and/or representative disagree with the determination, he has the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for MDCH website information.)

4.2.B. Provider Appeals

A retrospective determination that an applicant is not eligible for nursing facility services based on review of the functional/medical screening, is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

4.3 Admission Requirements

Prior to or upon admission, the nursing facility must provide residents and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with asterisk (*).

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- Rights as defined by federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know Your Rights" booklet; *
- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to the facility cannot be denied because the beneficiary is unable to pay in advance for non-covered services); *
- Facility policies regarding protection and maintenance of personal funds; *
- A description of the facility policies to implement advanced directives; *
- Facility policies regarding the availability of hospice care; *
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; * and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

4.4 PREADMISSION CONTRACTS

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (e.g., revocation of their Medicaid provider agreement).

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PACE ELIGIBILITY AND ENROLLMENT PROCESS

BENEFICIARY ELIGIBILITY AND ENROLLMENT PROCESS

There are eight necessary components of the PACE eligibility and enrollment process:

- **Verification of Medicaid Eligibility**
  Medicaid payment for PACE services requires a determination of Medicaid eligibility by MDCH.

- **Applicant Age of 55 Years or Older**
  The specific aim of PACE is to provide services for the older population. This age restriction is mandated by federal PACE requirements.

- **Residence in the Service Area of a PACE Organization**

- **Ability to live safely in the Community**
  At time of enrollment, a PACE participant must be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.

- **Assessment by a Multidisciplinary Team**
  Program enrollment requires a comprehensive assessment of participant needs by a multidisciplinary team.

- **Physician Orders**
  A physician written order for PACE program enrollment is required. The order must be dated and the physician degree must appear with the signature. The physician must initial a rubber-stamped signature.

- **Appropriate Placement Based on Completion of the Michigan Medicaid Nursing Facility Level of Care Determination**
  The PACE organization must verify beneficiary appropriateness for services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination form. MDCH will not reimburse services under Medicaid when the beneficiary does not meet the established criteria identified through the tool or the Nursing Facility Level of Care Exception process.

  A copy of the Michigan Medicaid Nursing Facility Level of Care Determination form and Field Definitions are attached (see Attachments A and B).

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. The PACE organization will be held responsible for providing Medicaid-reimbursable services for only those participants who meet the criteria outlined in this bulletin.

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool in the following situations:

  - all new enrollments of Medicaid-eligible beneficiaries
  - re-enrollment of Medicaid-eligible beneficiaries

- **Provision of Timely and Accurate Information to Support Informed Choice for all Appropriate Medicaid Options for Long Term Care**

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The Process Guidelines define required process steps for use of the electronic web-based form and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are attached (see Attachment C). When finalized, this document will be available on the MDCH website.

The revised functional/medical criteria include seven domains of need:

- Activities of Daily Living,
- Cognition,
- Physician Involvement,
- Treatments and Conditions,
- Skilled Therapies,
- Behavior, and
- Service Dependency.

For participants who qualify under only three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The electronic web-based tool must be completed only once for each admission or readmission to the program.

NURSING FACILITY LEVEL OF CARE DETERMINATION EXCEPTION PROCESS (NF LOC EXCEPTION PROCESS)

An exception process is available for those applicants who have demonstrated a significant level of long term care need, but do not meet the Michigan Medicaid Nursing Facility Level of Care Criteria. The Nursing Facility Level of Care Exception Process is initiated when the prospective provider telephones MDCH or its designee and requests review after the applicant has been determined ineligible using the web-based electronic tool. The NF LOC Exception criteria is attached (see Attachment D). When finalized, this information will be available on the MDCH website at www.michigan.gov/mdch. To request a NF LOC Exception review, providers may call xxx-xxx-xxxx.

TELEPHONE INTAKE GUIDELINES

The Telephone Intake Guidelines are a list of questions that identify potential PACE participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the PACE organization. A copy of the guidelines is attached (see Attachment E). When finalized, the guidelines will be available on the MDCH website.

ANNUAL RECERTIFICATION

PACE participants must undergo annual re-certification to establish that they continue to meet functional/medical eligibility requirements; however, participants must meet the nursing facility level of care definition on an ongoing basis for services to be reimbursed by Medicaid. The electronic web-based form must be completed only once for each admission or readmission. Initial comprehensive assessments, reassessments and progress notes must demonstrate that the participant has met the criteria on an ongoing basis.

RETROSPECTIVE REVIEW AND MEDICAID RECOVERY

At random and whenever indicated, MDCH will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination. If the participant is found to be ineligible for PACE services, MDCH will recover all Medicaid payments made for PACE services rendered during the period of ineligibility.

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ADVERSE ACTION NOTICE
When the provider determines that the applicant or current participant does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the provider must issue an adverse action notice to the applicant or his authorized representative. The provider must also offer the applicant referral information about services that may help meet his needs.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedure Manual explain the process by which each different case is brought to completion. The manual is available for review on the MDCH website. Refer to the Directory Appendix of the Medicaid Provider Manual Administrative Tribunal contact and website information.

IMMEDIATE REVIEW-ADVERSE ACTION NOTICES
MDCH or its designee will review all pre-admission or continued stay adverse action notices upon request by a Medicaid beneficiary or his representative. When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- MDCH or its designee will request that the PACE organization provide pertinent information by close of business of the first working day after the date of the beneficiary or representative receives the notice.

- MDCH or its designee will review the records, obtain information from the beneficiary or beneficiary representative, and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

The beneficiary (or representative) may still request an MDCH appeal of the Michigan Medicaid Nursing Facility Level of Care Determination.

FREEDOM OF CHOICE
When an applicant has been qualified to receive services under the nursing facility level of care criteria, he must be informed of his benefit options and elect, in writing, to receive services in a specific program. This election must take place prior to initiating PACE services.

The applicant, or legal representative, must be informed of the following:

- services available under the PACE
- services available in other community settings, such as the MI Choice program
- services available through Medicaid-reimbursed nursing facilities

If applicants are interested in nursing facility or other community-based care, the PACE organization must provide appropriate referral information using the Access Guidelines to State Services for Persons with Long Term Care Needs (see Attachment F). When finalized, these guidelines will be available on the MDCH website at www.michigan.gov/mdch.

Applicants must indicate their choice of program in writing by signing the Freedom of Choice form which is witnessed by the applicant's representative. A copy of the completed form must be retained for a period of three years for non-enrollees. The completed form must be kept in the medical record if the applicant chose to receive PACE services.

A copy of this form is included with the revised criteria (see Attachment A).

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APPLICANT APPEALS

- **Financial Eligibility**
  A determination that an applicant is financially not eligible for Medicaid is an adverse action. Applicants may appeal such an action to the Michigan Department of Community Health.

- **Functional/Medical Eligibility**
  A determination that an applicant is functionally/medically not eligible for PACE services is an adverse action. If the applicant and/or representative disagree with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the Administrative Tribunal portion of the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

PROVIDER APPEALS

A retrospective determination that a participant is ineligible for PACE services, based on review of the functional/medical screening, is an adverse action for the PACE organization if MDCH proposes to recover payments made. If the PACE organization disagrees with this determination, an appeal may be filed with MDCH. Refer to the Directory Appendix of the Medicaid Provider Manual for contact Administrative Tribunal contact information.

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MI CHOICE ELIGIBLITY AND ADMISSION PROCESS

BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

There are four necessary components of the MI Choice Program eligibility and admission process:

- **Verification of Medicaid Eligibility**
  Medicaid payment for MI Choice program services requires a determination of Medicaid eligibility by the Family Independence Agency (FIA). When a Medicaid-eligible or potentially-eligible beneficiary is admitted to the MI Choice program, the MI Choice Agent must submit the FIA Assistance Application Form (FIA-1171) to the local FIA office to establish/confirm beneficiary eligibility for Medicaid benefits. The FIA-1171 may be obtained through the local FIA office.

- **Physician Orders**
  A physician written order for MI Choice program admission is required. The order must be dated and the physician degree must appear with the signature. The physician must initial a rubber-stamped signature.

- **Appropriate Placement Based on Completion of the Michigan Medicaid Nursing Facility Level of Care Determination**
  The MI Choice program agent must verify beneficiary appropriateness for services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination form. The MI Choice program agent may not bill Medicaid for services provided when the beneficiary does not meet the established criteria identified through the tool or the Nursing Facility Level of Care Determination Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

  Claims for service dates prior to the electronic tool determination date will not be reimbursed by Medicaid. In addition, services will not be reimbursed when the determination does not demonstrate functional/medical eligibility through the electronic web-based tool.

  A copy of the Michigan Medicaid Nursing Facility Level of Care Determination form and Field Definitions are attached (see Attachments A and B). When finalized, the documents will be posted on the MDCH website at www.michigan.gov/mdch.

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. The MI Choice program agent will be held responsible for billing Medicaid for only those participants who meet the criteria outlined in this bulletin.

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool in the following situations:

  - all new admissions of Medicaid-eligible beneficiaries
  - readmissions of Medicaid-eligible beneficiaries after more than ten calendar days continuous absence from the MI Choice program**.**
  - non-emergency transfers of Medicaid-eligible beneficiaries to another MI Choice program agent, including transfers originating from a nursing facility that is undergoing a voluntary program closure
  - hospice-eligible beneficiaries who are being admitted to the MI Choice program for end-of-life care

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The Process Guidelines define required process steps for use of the electronic web-based form and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are attached (see Attachment C). When finalized, the guidelines will be available on the MDCH website.

The revised functional/medical criteria include seven domains of need:

- Activities of Daily Living,
- Cognition,
- Physician Involvement,
- Treatments and Conditions,
- Skilled Therapies,
- Behavior, and
- Service Dependency.

For participants who qualify under only three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The electronic web-based tool must be completed only once for each admission or readmission to the program.

Nursing Facility Level of Care Exception Process

An exception process is available for those applicants who have demonstrated a significant level of long term care need, but do not meet the Michigan Medicaid Nursing Facility Level of Care Criteria. The Nursing Facility Level of Care Exception Process is initiated when the prospective provider telephones MDCH or its designee and requests review after the applicant has been determined ineligible using the web-based electronic tool. The NF LOC Exception criteria is attached (see Attachment D). When finalized, this information will be available on the MDCH website at www.michigan.gov/mdch. To request a NF LOC Exception review, providers may call xxx-xxx-xxxx.

Telephone Intake Guidelines

The Telephone Intake Guidelines are a list of questions that identify potential MI Choice Program participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the MI Choice program agent. A copy of the guidelines is attachment (see Attachment E). When finalized, the guidelines will be available on the MDCH website.

The Telephone Intake Guidelines are the only acceptable tool for telephonic pre-screening.

Annual Re-certification

MI Choice program participants must undergo annual re-certification to establish that they continue to meet functional/medical eligibility requirements; however, participants must meet the nursing facility level of care definition on an ongoing basis for services to be reimbursed. The electronic web-based form must be completed only once for each admission or readmission. Quarterly Minimum Data Set-Home Care (MDS-HC) assessments and progress notes must demonstrate that the participant has met the criteria on an ongoing basis.

Retrospective Review and Medicaid Recovery

At random and whenever indicated, MDCH will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination and the quality of Medicaid MDS-HC data overall. If the participant is found to be ineligible for MI Choice program services, MDCH will

recover all payments made for services rendered during the period of ineligibility by making an adjustment during annual cost settlement

Adverse Action Notice
When the provider determines that the applicant or current participant does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the provider must issue an adverse action notice to the applicant or his authorized representative. The provider must also offer the applicant referral information about services that may help meet his needs.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedure Manual explain the process by which each different case is brought to completion. The manual is available on the Administrative Tribunal portion of the MDCH website. Refer to the Directory Appendix of the Medicaid Provider Manual Administrative Tribunal contact and website information.

Immediate Review-Adverse Action Notices
MDCH or its designee will review all pre-admission or continued stay adverse action notices upon request by a Medicaid beneficiary or his representative. When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- MDCH or its designee will request that the MI Choice program agent provide pertinent information by close of business of the first working day after the date of the beneficiary or representative receives the notice.

- MDCH or its designee will review the records, obtain information from the beneficiary or beneficiary representative, and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

The beneficiary (or representative) may still request an MDCH appeal of the Michigan Medicaid Nursing Facility Level of Care Determination.

- **Freedom of Choice**
  When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect, in writing, to receive services in a specific program. This election must take place prior to initiating MI Choice program services.

  The applicant, or legal representative, must be informed of the following:

  - services available under the MI Choice program
  - services available in other community settings, such as the PACE program
  - services available through Medicaid-reimbursed nursing facilities

  If applicants are interested in nursing facility or other community-based care, the MI Choice program agent must provide appropriate referral information using the Access Guidelines to State Services for Persons with Long Term Care Needs (see Attachment F).

  Applicants must indicate their choice of program in writing by signing the Freedom of Choice form which is witnessed by the applicant's representative. A copy of the completed form for non-enrollees must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chose to receive MI Choice program services.

  A copy of this form is included with the revised criteria (see Attachment A).

DRAFT

APPLICANT APPEALS

- **Financial Eligibility**
  A determination that an applicant is financially not eligible for Medicaid is an adverse action. Applicants may appeal such an action to the Family Independence Agency (FIA).

- **Functional/Medical Eligibility**
  A determination that an applicant is functionally/medically not eligible for MI Choice Program services is an adverse action. If the applicant and/or representative disagree with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

PROVIDER APPEALS

A retrospective determination that a participant is ineligible for MI Choice program services, based on review of the functional/medical screening, is an adverse action for the MI Choice Agent if MDCH proposes to recover payments made. If the MI Choice program agent disagrees with this determination, an appeal may be filed with MDCH. Refer to the Directory Appendix of the Medicaid Provider Manual for Administrative Tribunal contact and website information.

ATTACHMENT A

Michigan Medicaid Nursing Facility Level of Care Determination

Applicant's Name: Field 1 (Last) _____ (First) _____ (M.I.)

Provider Type: Field 4 **ID:** Field 5

Medicaid ID: Field 2

Provider Contact Name: Field 6 (Last) _____ (First)

Date of Birth: Field 3 / _____ / _____
00 / 00 / 0000

Provider Day Phone: ( ) Field 7 _____ - _____

Door 1: Activities of Daily Living

A. Bed Mobility: How the applicant moves to and from lying position, turns side to side, and positions body while in bed.

Field 8 ☐ **Independent**
No help or oversight, OR help, oversight provided only 1 or 2 times during last 7 days.

Field 9 ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.

Field 10 ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.

Field 11 ☐ **Extensive Assistance**
While the applicant performed part of activity, over last 7-day period, help of following types(s) provided 3 or more times:
- Weight-bearing support
- Full performance by another during part, but not all, of last 7 days

Field 12 ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.

Field 13 ☐ **Activity did not occur** during entire 7 days (regardless of ability).

B. Transfer: How the applicant moves between surfaces, to/from bed, chair, wheelchair, standing position (exclude to/from bath/toilet).

Field 14 ☐ **Independent**
No help or oversight, OR help, oversight provided only 1 or 2 times during last 7 days.

Field 15 ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provide only 1 or 2 times during last 7 days.

Field 16 ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.

Field 17 ☐ **Extensive Assistance**
While the applicant performed part of activity, over last 7-day period, help of following types(s) provided 3 or more times:
- Weight-bearing support
- Full performance by another during part, but not all, of last 7 days

Field 18 ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.

Field 19 ☐ **Activity did not occur** during entire 7 days (regardless of ability).

C. Toilet Use: How the applicant uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

Field 20 ☐ **Independent**
No help or oversight, OR help, oversight provided only 1 or 2 times during last 7 days.

Field 21 ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provide only 1 or 2 times during last 7 days.

Field 22 ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.

Field 23 ☐ **Extensive Assistance**
While the applicant performed part of activity, over last 7-day period, help of following types(s) provided 3 or more times:
- Weight-bearing support
- Full performance by another during part, but not all, of last 7 days

Field 24 ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.

Field 25 ☐ **Activity did not occur** during entire 7 days (regardless of ability).

D. Eating: How the applicant eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Field 26 ☐ **Independent**
No help or oversight, OR help, oversight provided only 1 or 2 times during last 7 days.

Field 27 ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provide only 1 or 2 times during last 7 days.

Field 28 ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.

Field 29 ☐ **Extensive Assistance**
While the applicant performed part of activity, over last 7-day period, with
- Full performance by another during part, but not all, of last 7 days

Field 30 ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.

Field 31 ☐ **Activity did not occur** during entire 7 days (regardless of ability).

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.

(A) Bed Mobility, (B) Transfers, and (C) Toileting:
- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

(D) Eating:
- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

Door 2: Cognitive Performance (Does the applicant have any problems with memory or making decisions?)

A. Short-term memory okay (seems/appears to recall after 5 minutes)

Field 32 ☐ **Memory Okay**

Field 33 ☐ **Memory Problem**

B. Cognitive skills for daily decision-making (made decisions regarding tasks of daily life for past seven days).

Field 34 ☐ **Independent**
The applicant's decisions were consistent and reasonable (reflecting lifestyle, culture, values); the applicant organized daily routine and made decisions in a consistent, reasonable, and organized fashion.

Field 35 ☐ **Modified Independent**
The applicant organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

Field 36 ☐ **Moderately Impaired**
The applicant's decisions were poor; the applicant required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

Field 37 ☐ **Severely Impaired**
The applicant's decision-making was severely impaired, the applicant never (or rarely) made decisions.

C. Making self understood (expressing information content, however able).

Field 38 ☐ **Understood**
The applicant expresses ideas clearly, without difficulty.

Field 39 ☐ **Usually Understood**
The applicant has difficulty finding the right words or finishing thoughts, resulting in delayed responses. If given time, little or no prompting required.

Field 40 ☐ **Sometimes Understood**
The applicant has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).

Field 41 ☐ **Rarely/Never Understood**
At best, understanding is limited to interpretation of highly individual, applicant-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem and Making Self Understood "Sometimes Understood" or "Rarely/Never Understood."

Door 3: Physician Involvement (Is the applicant under the care of a physician for treatment of an unstable medical condition?)

Field 42 **A. Physician Visits:** In the last 14 days, how many days has the physician, or authorized assistant or practitioner, examined the applicant? Do not count emergency room exams. Enter zero if none.

☐☐

Field 43 **B. Physician Orders:** In the last 14 days, how many days has the physician, or authorized assistant or practitioner, changed the applicant's orders? Do not include drug or treatment order renewals without change. Enter zero if none.

☐☐

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3.

1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

Door 4: Treatments and Conditions (Has the applicant in the last 14 days received any of the following health treatments, or demonstrated any of the following health conditions?) Complete each item below, either No or Yes.

		Yes	No
Field 44/45	A. Stage 3-4 pressure sores	☐	☐
Field 46/47	B. IV or parenteral feedings	☐	☐
Field 48/49	C. Intravenous medications	☐	☐
Field 50/51	D. End-stage care	☐	☐
Field 52/53	E. Daily tracheostomy care, daily respiratory care, daily suctioning	☐	☐
Field 54/55	F. Pneumonia within the last 14 days	☐	☐
Field 56/57	G. Daily oxygen therapy	☐	☐
Field 58/59	H. Daily insulin or anti-glycemic with two order changes in last 14 days	☐	☐
Field 60/61	I. Peritoneal or hemodialysis	☐	☐

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories to qualify under Door 4.

Door 5: Skilled Rehabilitation Therapies (Is the applicant currently receiving any skilled rehabilitation therapies?)

Record the total minutes each of the following therapies was administered or scheduled (for at least 15 minutes a day) in the last 7 days. Enter zero if none or less than 15 minutes daily.

A = Total number of minutes provided in last 7 days

B = Total number of minutes scheduled but not yet administered

		A	B
1. Speech Therapy	Fields	62	63
2. Occupational Therapy	Fields	64	65
3. Physical Therapy	Fields	66	67

Example:

A	B
210	60

Scoring Door 5: The applicant must have required at least 45 minutes of ST, OT or PT scheduled or delivered in the last 7 days to qualify under Door 5.

Door 6: Behavior (Has the applicant displayed any challenging behaviors in the last 7 days?)

Behavioral Code:

0 = Behavior not exhibited in last 7 days
1 = Behavior of this type occurred 1 to 3 days in last 7 days
2 = Behavior of this type occurred 4 to 6 days, but less than daily
3 = Behavior of this type occurred daily

Behavioral Symptoms:

		0	1	2	3
A. **Wandering** - Moved with no rational purpose, seemingly oblivious to needs and safety.		☐	☐	☐	☐
	Fields	68	69	70	71
B. **Verbally Abusive** - Others were threatened, screamed at, cursed at.		☐	☐	☐	☐
	Fields	72	73	74	75
C. **Physically Abusive** - Others were hit, shoved scratched, sexually abused.		☐	☐	☐	☐
	Fields	76	77	78	79
D. **Socially Inappropriate/Disruptive** - Made disruptive sounds, noisiness, screaming, self-abusive acts, inappropriate sexual behavior or disrobing in public, smeared or threw food/feces, hoarded or rummaged through others' belongings.		☐	☐	☐	☐
	Fields	80	81	82	83
E. **Resists Care -** Resisted taking medications or injections, ADL assistance or eating.		☐	☐	☐	☐
	Fields	84	85	86	87

Problem Condition Code: If present at any point in last 7 days, code either No or Yes.

Problem Conditions:

		No	Yes
A. Delusions		☐	☐
	Fields	88	89
B. Hallucinations		☐	☐
	Fields	90	91

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

1. A "Yes" for either delusions or hallucinations within the last 7 days.
2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive Behavioral Symptoms, Physically Abusive Behavioral Symptoms, Socially Inappropriate/Disruptive Behavioral Symptoms or Resisted Care.

Door 7: Service Dependency

The applicant is currently being served by either the MI Choice Waiver program, PACE program or Medicaid reimbursed nursing facility.

Field 92 ☐ **Program participant for at least one year** and requires ongoing services to maintain current functional status. No other community, residential or informal services are available to meet the applicant's needs.

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency to qualify under Door 7.

ATTACHMENT A

FREEDOM OF CHOICE

Applicant's Name: Field 93 Date of Birth: Field 94

Representative (if any): Field 95

SECTION I - MEDICAL/FUNCTIONAL ELIGIBILITY

Based on an assessment of functional abilities and needs conducted on Field 96 (*date*), the applicant indicated above:

Field 97 ☐ **Does** meet the functional/medical eligibility criteria for Medicaid LTC programs by scoring in Door Field 98.

Field 99 ☐ **Does Not** meet the functional/medical eligibility criteria for Medicaid NF Level of Care (please proceed to Section III) Field 100 Eligibility Option Button

Field 101	Field 102	Field 103
Signature of professional completing assessment	Title	Date

SECTION II - FREEDOM OF CHOICE

I have been advised that I meet functional/medical eligibility and choose to receive services and supports under the following program:

Field 104 ☐ Community-based care. I have received local referral information.

Local Referrals: Field 105

Field 106 ☐ Nursing facility care. I have received information about nursing facilities in my area.

Field 107 ☐ PACE Program. I have received information about the PACE program.

Field 108	Field 109	Field 110
Signature of applicant	Signature of applicant's representative	Date

SECTION III - APPEAL RIGHTS

Field 111 Appeals Option Button

I have received a copy of a denial of service based on this determination and understand my right to appeal.

Field 112	Field 113	Field 114
Signature of applicant	Signature of applicant's representative	Date

Option Screen from Section I "Eligibility Option Button" of Freedom of Choice form:

Field 115 ☐ Please hold this review for 30 days. The provider will contact the vendor for an exception request.

Field 116 ☐ A formal adverse action notice has been provided. The applicant has been referred for other community program options to:

_____

_____

_____

Michigan Medicaid Nursing Facility Level of Care Determination

Field Definitions

Fields One through Seven
Applicant and Provider Information

Field 1: Applicant's Name
Enter the full name of the applicant in the following order: last name, first name, and middle initial.

Field 2: Medicaid ID
Enter the Medicaid identification number in this field when known. The system will not allow billing for this applicant until this field is completed with a valid Medicaid beneficiary identification number.

Field 3: Date of Birth
Enter the applicant's date of birth in the following format: MM/DD/YYYY.

Field 4: Provider Type
Enter the organization provider type.
PACE 17
Nursing Facility..... 60
Inpatient CMCF 61
Hospital LTCF 62
Vent/Swing Bed Unit 63
MI Choice Waiver Program 77

Field 5: Medicaid ID
Enter the Medicaid provider number.

Field 6: Provider Contact Name
List the agency contact person for the applicant in the following order: last name, first name.

Field 7: Provider Day Phone
List the phone number for the contact person for this applicant.

Fields Eight through Thirty-One
Door 1: Activities of Daily Living

Most applicants who qualify for the Michigan Medicaid nursing facility level of care criteria will qualify under Activities of Daily Living. This set of criteria has been designed to identify those applicants with a significant loss of independent function.

An individual can vary in ADL performance from day to day. It is important to capture the total picture of ADL performance over a seven-day period. The seven-day period look-back is based on the date of eligibility determination. Information should be obtained from multiple sources when available. Since accurate coding is important for making eligibility decisions, be sure to consider each activity definition fully.

The wording used in each coding option reflects real life situations where slight variations are common. When variations occur, the coding ensures that the applicant is not assigned to an excessively independent or dependent category. Codes permit one or two exceptions for the provision of additional care before the applicant is categorized as more dependent.

To evaluate the applicant's ADL performance, begin by observing physical tasks. Talk with the applicant to ascertain what he /she does for each ADL activity as well as the type and level of assistance by others. Also, talk with family members and others when possible and weigh all responses to determine a consistent picture of ADL performances. The following list provides general guidelines for recording accurate ADL self-performance.

~~ Guidelines for ADL Performance ~~

- Do not confuse an applicant who is totally dependent in an ADL activity with one where the activity itself is not occurring. For example, an applicant who receives tube feedings and no foods or fluids by mouth is engaged in eating, and must be evaluated under the eating category for his/her level of assistance in the process.
- An applicant who is highly involved in providing him/herself a tube feeding is not totally dependent and should not be coded as 'total dependence', but rather as a lower code depending on the nature of help received from others.
- Each of the ADL performance codes is exclusive; there is no overlap between categories. Changing from one category to another demands an increase or decrease in the number of times help is provided.

Bed Mobility

This section refers to the applicant's ability to move to and from a lying position, to turn side to side, and to position the body while in bed. The seven-day look-back period is based on the date of eligibility determination.

Field 8: Independent

Select this box when the applicant is independent. Independent means the applicant needs no help or oversight, OR help or oversight was provided only 1 or 2 times in the last 7 days.

Field 9: Supervision

Select this box when the applicant required oversight, encouragement or cueing 3 or more times during the last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.

Field 10: Limited Assistance

Select this box when the applicant is highly involved in the activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR additional help was provided only 1 or 2 times during last 7 days.

Field 11: Extensive Assistance

Select this box when the applicant performed part of activity over last 7-day period, and help of the following type(s) was provided 3 or more times:

- Weight-bearing support
- Full performance by another individual during part, but not all, of last 7 days

Field 12: Total Dependence

Select this box when the applicant required full performance of activity by another individual during entire 7-day period.

Field 13: **Activity did not occur** during entire 7-day period (regardless of ability). Select this box when the activity did not occur for this applicant.

Transfers

This section refers to the applicant's ability to move between surfaces, to/from a bed, chair, wheelchair, and to a standing position (excluding to/from bath/toilet). The seven-day look-back period is based on the date of eligibility determination.

Field 14: **Independent**

Select this box when the applicant is independent. Independent means the applicant needs no help or oversight, OR help or oversight was provided only 1 or 2 times in the last 7 days.

Field 15: **Supervision**

Select this box when the applicant required oversight, encouragement or cueing 3 or more times during the last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.

Field 16: **Limited Assistance**

Select this box when the applicant is highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR additional help was provided only 1 or 2 times during last 7 days.

Field 17: **Extensive Assistance**

Select this box when the applicant performed part of activity over last 7-day period, and help of the following type(s) was provided 3 or more times:

- Weight-bearing support
- Full performance by another individual during part, but not all, of last 7 days

Field 18: **Total Dependence**

Select this box when the applicant required full performance of activity by another individual during entire 7-day period.

Field 19: **Activity did not occur** during entire 7-day period (regardless of ability). Select this box when the activity did not occur for this applicant.

Toilet Use

This section refers to how well the applicant uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. The seven-day look-back period is based on the date of the eligibility determination.

Field 20: **Independent**

Select this box when the applicant is independent. Independent means the applicant needs no help or oversight, OR help or oversight was provided only 1 or 2 times in the last 7 days.

Field 21: **Supervision**

Select this box when the applicant required oversight, encouragement or cueing 3 or more times during the last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.

Field 22: Limited Assistance
Select this box when the applicant is highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR additional help was provided only 1 or 2 times during last 7 days.

Field 23: Extensive Assistance
Select this box when the applicant performed part of activity over last 7-day period, and help of the following type(s) was provided 3 or more times:

- Weight-bearing support
- Full performance by another individual during part, but not all, of last 7 days

Field 24: Total Dependence
Select this box when the applicant required full performance of activity by another during entire 7-day period.

Field 25: Activity did not occur during entire 7-day period (regardless of ability).
Select this box when the activity did not occur for this applicant.

Eating
This section refers to how the applicant eats and drinks (regardless of skill and includes intake of nourishment by other means, e.g., tube feeding, total parenteral nutrition). The seven-day look-back period is based on the date of the eligibility determination.

Field 26: Independent
Select this box when the applicant is independent. Independent means the applicant needs no help or oversight, OR help or oversight was provided only 1 or 2 times in the last 7 days.

Field 27: Supervision
Select this box when the applicant required oversight, encouragement or cueing 3 or more times during the last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.

Field 28: Limited Assistance
Select this box when the applicant is highly involved in activity, received physical help in guided maneuvering of limbs or other assistance 3 or more times, OR additional help was provided only 1 or 2 times during last 7 days.

Field 29: Extensive Assistance
Select this box when the applicant performed part of activity over last 7-day period, and help of the following type(s) was provided 3 or more times:

- Full performance by another individual during part, but not all, of last 7 days

Field 30: Total Dependence
Select this box when the applicant required full performance of activity by another during entire 7-day period.

Field 31: Activity did not occur during entire 7-day period (regardless of ability).
Select this box when the activity did not occur for this applicant.

Scoring for Door 1 – Activities of Daily Living

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.

(A) Bed Mobility, (B) Transfers, and (C) Toileting:
- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

(D) Eating:
- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

Fields Thirty-Two through Forty-One
Door 2: Cognitive Performance

The Michigan nursing facility level of care definition is meant to include applicants who need assistance based on cognitive performance. Door 2 uses the Cognitive Performance Scale to identify applicants with cognitive difficulties, especially difficulties with short-term memory and daily decision-making, both essential skills for residing safely in the community.

The applicant's ability to remember, think coherently, and organize daily self-care activities is very important. The focus is on performance, including a demonstrated ability to remember recent events and perform key decision-making skills.

Questions about cognitive function and memory can be sensitive issues for some applicants who may become defensive, agitated, or very emotional. These are common reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated when the applicant knows he/ she cannot answer the questions cogently.

Be sure to interview the applicant in a private, quiet area without distraction (not in the presence of others, unless the applicant is too agitated to be left alone). Using a nonjudgmental approach to questioning will help create a needed sense of trust. Be cognizant of possible cultural differences that may affect your perception of the applicant's response. After eliciting the applicant's responses to questions, return to the family or specific caregivers as appropriate to clarify or validate information regarding cognitive function over the last seven days. For applicants with limited communication skills or who are best understood by family or specific caregivers, you would need to carefully consider their insights in this area.

- Engage the applicant in general conversation to help establish rapport.
- Actively listen and observe for clues to help you structure your assessment. Remember: repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but these behaviors also provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the applicant.

An accurate assessment of cognitive function can be difficult when the applicant is unable to verbally communicate. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the applicant (memory recall). It is certainly easier to perform an evaluation when you can converse with the applicant and hear responses that give you clues as to how the applicant is able to think, if he/she understands his/her strengths and weaknesses, whether he/she is repetitive, or if he/she has difficulty finding the right words to tell you what they want to say.

Short Term Memory

The intent of this section is to determine the applicant's functional capacity to remember recent events (i.e., short term memory).

Process

Ask the applicant to describe a recent event both of you had the opportunity to remember – you can base this on an event or circumstance that you both experienced. After 5 minutes ask the applicant about the recent event. Additional methods of assessment include:

- Current season: able to identify the current season (correctly refers to the weather for the time of the year, next legal holiday, religious celebrations, etc.).
- Location of own room: able to locate and recognize own room or home.
- Family and friends names/faces: able to distinguish staff from family or strangers.
- Recent events: ask the applicant to describe the breakfast meal or activity just completed.
- Recent events: ask the applicant to remember three items (e.g., cook, watch, table) for a few minutes. After you have stated all three items, ask the applicant to repeat them to verify that you were heard and understood. Then proceed to talk about something else – do not be silent, do not leave the room. After five minutes ask the applicant to repeat the name of each item. If the applicant is unable to recall all three items, code 'memory problem.'

If there is no positive indication of memory ability, select Field 33 noting that the applicant has a memory problem.

Field 32: Memory Okay

Select this field when the applicant seems/appears to recall after 5 minutes.

Field 33: Memory Problem

Select this field when the applicant does not recall after 5 minutes.

Cognitive Skills for Daily Decision Making

The intent of this section is to record the applicant's actual performance in making everyday decisions about the tasks or activities of daily living. This item is especially important for further assessment in that it can alert the assessor to a mismatch between the applicant's abilities and his/her current level of performance, or that the family may inadvertently be fostering the applicant's dependence.

Process

It is suggested that you consult with the applicant first, then, if possible, a family member. Observations of the applicant can also be helpful. Review the events of the last seven days. The seven-day look-back period is based on the date of the eligibility determination. The inquiry should focus on whether the applicant is actively making his/her decisions, and not whether there is a belief that the applicant might be capable of doing so. Remember, the intent of this item is to record what the applicant is doing. When a family member takes decision-making responsibility away from the applicant regarding tasks of everyday living, or the applicant does not participate in decision making, whatever his/her level of capability, the applicant should be considered to have impaired performance in decision making.

Examples of Decision Making

- Choosing appropriate items of clothing
- Knowing when to go to meals
- Knowing and using space in home appropriately
- Using environmental cues to organize and plan the day, (clocks and calendars)
- Seeking information appropriately (not repetitively) from family or significant others in order to plan the day
- Using awareness of one's own strengths and limitations in regulating the day's events (asks for help when necessary)
- Knowing when to go out of the house
- Acknowledging the need to use a walker, and using it faithfully

Field 34: Independent

Select this field when the applicant's decisions were consistent and reasonable (reflecting lifestyle, culture, values); the applicant organized daily routine and made decisions in a consistent, reasonable, and organized fashion.

Field 35: Modified Independent

The applicant organized daily routines and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

Field 36: Moderately Impaired

The applicant's decisions were poor; the applicant required reminders, cues, and upervision in planning, organizing, and correcting daily routines.

Field 37: Severely Impaired

The applicant's decision-making was severely impaired; the applicant never (or rarely) made decisions.

Making Self Understood

The intent of this section is to document the applicant's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

Interact with the applicant. Observe and listen to the applicant's efforts to communicate with you. If possible, observe his or her interactions with family.

Field 38: Understood

The applicant expresses ideas clearly and without difficulty.

Field 39: Usually Understood
The applicant has difficulty finding the right words or finishing thoughts, resulting in delayed responses. If given time, little or no prompting is required.

Field 40: Sometimes Understood
The applicant has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).

Field 41: Rarely/Never Understood
At best, understanding is limited to interpretation of highly individual, applicant-specific sounds or body language (e.g., indicates the presence of pain or need to toilet).

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem and Making Self Understood "Sometimes Understood" or "Rarely/Never Understood."

Fields Forty-Two through Forty-Three
Door 3: Physician Involvement

Applicants who have significant clinical instability may be appropriate for long-term care programs. Door 3 records information concerning the frequency of health care practitioner visits and order changes for the applicant. For this section, visits and orders from physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician should be included. Do not count visits or orders made while the applicant was hospitalized.

Physician orders include written, telephoned, faxed, or consultation orders for new or altered treatments in the community setting. Drug renewal orders are not to be considered.

Field 42: Physician Visits
Identify the number of days within the last 14 days that the physician or authorized assistant or practitioner examined the applicant. The 14-day look-back period is based on the eligibility determination date. Do not count emergency room examinations). Enter zero if none.

Field 43: Physician Orders
Enter the number of days the physician or authorized assistant or practitioner changed the applicant's orders within the last 14 days. The 14-day look-back period is based on the eligibility determination date. Do not include drug or treatment order renewals without change. Enter zero if none. Physician orders in the emergency room do count.

A sliding scale dosage schedule that is written to cover different insulin dosages depending on laboratory values does not count as an order change simply because a different dose was administered based on sliding scale guidelines.

Do not count visits or orders prior to the last 14 days. If a resident has multiple physicians, and they all visit and write orders on the same day, this must be coded as one day in which a physician visited and one day for an order change.

Orders requesting a consultation by another physician may be counted; however, the order must be related to a possible new or altered treatment.

Scoring Door 3: The applicant must meet either of the following to qualify under Door 3.

1. At least one Physician Visit for examination AND at least four Physician Order changes in the last 14 days, OR
2. At least two Physician Visits for examination AND at least two Physician Order changes in the last 14 days.

Applicants who score in only Door 3 are those who most likely require ongoing assessment and follow-up monitoring. Care planning for these applicants must include restorative nursing interventions and a specific discharge plan. Restorative nursing interventions are discussed in the Michigan Medicaid Nursing Facility Level of Care Determination Process Guidelines.

Fields Forty-Four through Sixty-One
Door 4: Treatments and Conditions

Certain treatments and conditions may be a predictor of potential frailty or increased health risk. These conditions require a physician-documented diagnosis in the medical record. Applicants will not qualify under Door 4 when the conditions have been resolved, or they no longer affect functioning or the need for care. It is required that an active restorative nursing and discharge plan be developed and used as the focus for treatment. Unless otherwise noted, score each item for the last 14-day timeframe. The 14-day look-back period is based on the eligibility determination date.

Field 44/45: Stage 3-4 Pressure Sores
Select the 'yes' box if the applicant has stage 3-4 pressure sores.

Field 46/47: IV or Parenteral Feedings
Select the 'yes' box if the applicant received IV or parenteral feedings.

Field 48/49: Intravenous Medications
Select the 'yes' box if the applicant receives intravenous IV medications.

Field 50/51: End-stage Care
Select the 'yes' box if the applicant receives end-stage care.

Field 52/53: Daily Tracheostomy Care, Daily Respiratory Care, Daily Suctioning
Select the 'yes' box if the applicant receives tracheostomy care, daily respiratory care, or daily suctioning.

Field 54/55: Pneumonia Within The Last 14 Days
Select the 'yes' box if the applicant has pneumonia within the last 14 days AND has associated IADL/ADL needs or restorative nursing care.

Field 56/57: Daily Oxygen Therapy
Select the 'yes' box if the applicant receives daily oxygen therapy.

Field 58/59: Daily Insulin or Anti-Glycemic Drug with Two Order Changes in the Last 14 Days
Select the 'yes' box if the applicant receives daily insulin injections with two or more order changes within the last 14 days.

Field 60/61: Peritoneal or Hemodialysis
Select the 'yes' box if the applicant receives peritoneal or hemodialysis.

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories to qualify under Door 4.

Applicants who score at Door 4 require ongoing assessment and follow-up monitoring. Care planning for these applicants must include restorative nursing interventions and a specific discharge plan, except for those receiving end-or-life care. Restorative nursing interventions are discussed in the Michigan Medicaid Nursing Facility Level of Care Determination Process Guidelines.

Fields Sixty-Two through Sixty-Seven
Door 5: Skilled Rehabilitation Therapies

This section identifies the presence of rehabilitation interventions based on ordered and scheduled therapy service (physical therapy - PT, occupational therapy - OT, speech therapy - ST) needs during the past 7 days. The seven-day look-back period is based on the eligibility determination date.

Speech Therapy
Record the total minutes that speech therapy was administered or scheduled (for at least 15 minutes a day) in the last 7 days. Enter zero if none or less than 15 minutes daily.

Field 62: Minutes
Record the total number of speech therapy minutes from all disciplines provided in the last 7 days. Do not include evaluation minutes in the total number of minutes.

Field 63: Scheduled Therapies
Enter the estimated total number of speech therapy minutes (across all therapies) that the applicant was scheduled to receive in the last 7 days. Do not include evaluation minutes in the estimated number of minutes.

Occupational Therapy
Record the total minutes that occupational therapy was administered or scheduled (for at least 15 minutes a day) in the last 7 days. Enter zero if none or less than 15 minutes daily.

Field 64: Minutes
Record the total number of occupational therapy minutes from all disciplines provided in the last 7 days. Do not include evaluation minutes in the total number of minutes.

Field 65: Scheduled Therapies
Enter the estimated total number of occupational therapy minutes (across all therapies) that the applicant was scheduled to receive in the last 7 days. Do not include evaluation minutes in the estimated number of minutes.

Physical Therapy

Record the total minutes that physical therapy was administered or scheduled (for at least 15 minutes a day) in the last 7 days. Enter zero if none or less than 15 minutes daily.

Field 66: Minutes
Record the total number of physical therapy minutes from all disciplines provided in the last 7 days. Do not include evaluation minutes in the total number of minutes.

Field 67: Scheduled Therapies
Enter the estimated total number of physical therapy minutes (across all therapies) that the resident was scheduled to receive in the past 7 days. Do not include evaluation minutes in the estimate number of minutes.

Applicants who score in only Door 5 require ongoing assessment and follow-up monitoring. Care planning for these applicants must include restorative nursing interventions and a specific discharge plan. Restorative nursing interventions are discussed in the Michigan Medicaid Nursing Facility Level of Care Determination Process Guidelines.

Scoring Door 5:	The individual must have required at least 45 minutes of PT, OT or ST scheduled or delivered in the last 7 days to qualify under Door 5.

Fields Sixty-Eight through Ninety-One
Door 6: Behavior

This Door identifies applicants who display repetitive behavioral challenges. For this area, identify whether the applicant has displayed any challenging behaviors in the past 7 days. The seven-day look-day period is based on the eligibility determination date.

Wandering

Wandering describes those applicants who move about in or out of doors with no discernible, rational purpose. Individuals who wander may be oblivious to their physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry applicant moving about the apartment in search of food). Wandering may be by walking or by wheelchair. Do not include pacing as wandering behavior.

Field 68: 0 - Behavior not exhibited in last 7 days

Field 69: 1 - Behavior of this type occurred 1-3 days in last 7 days

Field 70: 2 - Behavior of this type occurred 4-6 days, but less than daily

Field 71: 3 - Behavior of this type occurred daily

Verbally Abusive
This section identifies applicants who threatened, screamed at, or cursed at others.

Field 72: 0 - Behavior not exhibited in last 7 days

Field 73: 1 - Behavior of this type occurred 1-3 days in last 7 days

Field 74: 2 - Behavior of this type occurred 4-6 days, but less than daily

Field 75: 3 - Behavior of this type occurred daily

Physically Abusive
This section identifies applicants who hit, shoved, scratched or sexually abused others.

Field 76: 0 - Behavior not exhibited in last 7 days

Field 77: 1 - Behavior of this type occurred 1-3 days in last 7 days

Field 78: 2 - Behavior of this type occurred 4-6 days, but less than daily

Field 79: 3 - Behavior of this type occurred daily

Socially Inappropriate/Disruptive
This section identifies applicants who made disruptive sounds, noisiness, or screaming, who performed self-abusive acts, inappropriate sexual behavior or disrobed in public, who smeared or threw food/feces, or who hoarded or rummaged through others' belongings.

Field 80: 0 - Behavior not exhibited in last 7 days

Field 81: 1 - Behavior of this type occurred 1-3 days in last 7 days

Field 82: 2 - Behavior of this type occurred 4-6 days, but less than daily

Field 83: 3 - Behavior of this type occurred daily

Resists Care
This section identifies applicants who resisted taking medications or injections, ADL assistance or eating. This applicant may have pushed a caregiver during ADL assistance. This category does not include instances where the applicant has made an informed choice not to follow a course of care (the applicant has exercised his/her right to refuse treatment and reacts negatively as others try to re-institute treatment).

Signs of resistance may be verbal or physical (e.g., physically refusing care, pushing caregiver away, scratching caregiver).

Take an objective view of the applicant’s behavioral symptoms. The coding for this item focuses on the applicant's actions, not intent. The fact that family members may have become used to the behavior and minimize the applicant's presumed intent is not pertinent to this coding. Does the applicant manifest the behavioral symptom or not? – this is the test you should use in coding these items.

Observe the applicant or significant others during assessment. Observe how the applicant responds to attempts by family members or significant others to assist him/her care. Consult with family members who provide direct care. Ask if they know what occurred throughout the day and night for the last seven days.

Field 84: 0 - Behavior not exhibited in last 7 days

Field 85: 1 - Behavior of this type occurred 1-3 days in last 7 days

Field 86: 2 - Behavior of this type occurred 4-6 days, but less than daily

Field 87: 3 - Behavior of this type occurred daily

Problem Conditions

Applicants who need long term care may experience delusions and hallucinations that impact the applicant's ability to live independently in the community. Applicants who qualify at this door must also meet the PASARR requirements for nursing facility admission if they choose a residential setting for care.

Field 88/89: Delusions (No/Yes)
Select the yes field when the applicant has exhibited delusional thinking within the last 7 days.

Field 90/91: Hallucinations (No/Yes)
Select the yes field when the applicant has clearly demonstrated having experienced hallucinations within the last 7 days.

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

1. A "yes" for either delusion or hallucinations within the last 7 days.
2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive Behavioral Symptoms, Physically Abusive Behavioral Symptoms, Socially Inappropriate/Disruptive Behavioral Symptoms or Resisted Care.

Field Ninety-Two
Door 7: Service Dependency

This section refers to applicants who are currently enrolled in and receiving services from either the MI Choice Program, PACE program or a Medicaid reimbursed nursing facility. The applicant qualifying under Door 7 is eligible for continued enrollment and delivery of services from these programs.

Field 92: Program participant for at least one year
The applicant has been served by MI Choice, PACE or by a Medicaid reimbursed nursing facility for at least one year AND requires ongoing services to maintain current functional status. No other community, residential or informal services are available to meet the applicant's needs.

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency to qualify under Door 7.

Fields Ninety-Three through One Hundred Fourteen
Freedom of Choice Form

Field 93: Applicant's Name
The full name of the applicant will be automatically generated. If a benenficiary's number was entered, that number will also be generated following the applicant's name.

Field 94: Date of Birth
The applicant's date of birth will be automatically generated.

Field 95: Representative's Name
Enter the full name of the applicant's representative, if applicable.

Field 96: Date of Assessment
The date of the assessment will be automatically generated.

Field 97: Does Meet Functional/Medical Eligibility
This box will be automatically selected if the applicant meets the functional/medical eligibility for Medicaid LTC programs.

Field 98: Door Number
The Door Number the applicant qualified under will be automatically generated.

Field 99: Does Not Meet Functional/Medical Eligibility
This box will be automatically selected if the applicant does not meet the functional/medical eligibility for Medicaid LTC programs.

Field 100: Eligibility Option Button

The Eligibility Option Button appears only when the "Does Not meet the functional/medical eligibility…" box is selected. Selecting the Eligibility Option Button generates an option screen with two choices:

1. Please hold the review for 30 days and the provider will contact the vendor for an exception request (field 118)

2. A formal adverse action notice has been provided. The provider lists other community options for the applicant (field 119).

Field 101: Signature of Professional Completing Assessment
The professional completing the assessment on behalf of the applicant must sign the Freedom of Choice form.

Field 102: Title
Provide the Title of the professional completing the assessment on behalf of the applicant.

Field 103: Date
Provide the Date the professional completed the assessment on behalf of the applicant.

Section II - Freedom of Choice

Field 104: Community-Based Care
The eligible applicant selects this box in acknowledgement of having received information on community-based care.

Field 105: Local Referrals
List the local referrals provided to the applicant.

Field 106: Nursing Facility Care
The eligible applicant selects this box in acknowledgement of having received information on nursing facility care.

Field 107: PACE
The eligible applicant selects this box in acknowledgement of having received information on the PACE program.

Field 108: Signature of Applicant
The applicant must sign the Freedom of Choice form.

Field 109: Signature of Applicant Representative
The applicant's representative (if any) must sign the Freedom of Choice form.

Field 110: Date
The applicant, or the applicant's representative (if any) must date the Freedom of Choice form.

Section III - Appeal Rights

Field 111: Appeals Option Button
When an applicant does not meet functional/medical eligibility they can select the Appeals Option Button. This will generate a screen containing contact information for the appeals process.

Field 112: Signature of Applicant
The ineligible applicant must sign the Freedom of Choice form in acknowledgement of having been advised in writing of his functional/medical eligibility and the right to appeal the assessment.

Field 113: Signature of Applicant Representative
The ineligible applicant's representative, if applicable, must sign the Freedom of Choice form on behalf of the applicant in acknowledgement that the applicant has been advised in writing of his functional/medical eligibility and the right to appeal the assessment.

Field 114: Date
The ineligible applicant, or ineligible applicant's representative, if applicable, must date the Freedom of Choice form.

Fields One Hundred Fifteen through One Hundred Sixteen Option Screen

Selecting the Eligibility Option Button generates an Option Screen.

Note: the Eligibility Option Button appears only when the applicant Does Not meet the NF LOC Functional/Medical criteria.

Field 115: Option Screen "Please Hold Review for 30 Days."
Select this box when the provider plans to request a Nursing Facility Level of Care Exception for the applicant.

Field 116: Option Screen "A Formal Adverse Action Notice Has Been Provided."
Select this box when the provider issues to the applicant a formal adverse action notice. The provider then furnishes a list to the applicant of other community program options.

Exception Review Process

Applicants who believe that they have higher-level service needs than identified through the eligibility criteria may request an exception review. Providers may request a review through MDCH or its designee by telephone or in the MDCH website Directory Appendix at www.Michigan.gov/xxxxx.

ATTACHMENT C

Michigan Department of Community Health
Michigan Medicaid Nursing Facility Level of Care Determination
Process Guidelines

TABLE OF CONTENTS

BACKGROUND

This document presents the process requirements for admission to three specific long term care programs in Michigan: Medicaid-reimbursed nursing facility care, MI Choice Program for Elderly and Disabled, and the Program for All Inclusive Care for the Elderly (PACE). These guidelines further define the underlying principles for these programs, and speak specifically to the admission process.

The Michigan Department of Community Health (MDCH) works to ensure that program participants have control over the quality of their life, and that the services they receive are provided in the most efficient and integrated setting or program. Two core elements assist in achieving these goals: person-centered principles and informed choice. Additionally, participants with more acute and perhaps less chronic needs must be provided nursing restorative care and discharge planning when appropriate. Guidelines for these requirements are also included.

INFORMED CHOICE

The concept of informed choice is at the heart of the Michigan Department of Community Health admission process for long term care services. It is essential that program applicants and/or their representatives fully understand all available options under Medicaid.

Medicaid-reimbursed nursing facility care, the MI Choice Program for Elderly and Disabled, and PACE must utilize equivalent functional/medical eligibility criteria as stated by federal law (Social Security Act, Sections 1915c, 1919a, and 1934).

When qualifying for any one of these programs, applicants will automatically meet the functional/medical eligibility criteria for all three programs. When programs are open to new enrollment, MDCH wants to ensure that applicants are afforded the opportunity to make an informed choice about where their needs can best be met.

Michigan's Informed Choice Process ensures that information, education, and referral systems are available and working to provide the opportunity to make such informed choices. Each of the above program entry points are required to make pertinent information available to each potential participant.

BEGINNING THE PROCESS . . .

DETERMINATION OF FUNCTIONAL/MEDICAL ELIGIBILITY

MDCH requires use of an electronic web-based tool to determine functional/medical eligibility for programs required to use the nursing facility level of care criteria. The end result of this electronic system is a document titled "Freedom of Choice." The electronic system automatically identifies the applicant and the functional/medical eligibility determination and documents this information on the Freedom of Choice form (which can be found with the Michigan Medicaid Nursing Facility Level of Care Determination in the Forms Appendix and website at xxxxxxx). Applicants who do not meet the eligibility criteria have the option to request a review from MDCH or its designee.

APPLICANT IS DETERMINED FUNCTIONALLY/MEDICALLY ELIGIBLE . . .

PROVIDER IS REQUIRED TO REVIEW ALL OPTIONS WITH APPLICANT

Upon determination of functional/medical eligibility, the provider must explain all three program options to the applicant, as well as other Medicaid and community programs when appropriate. The provider should rely on the Access Guidelines to State Services for Persons with Long Term Care Needs (termed *Access Guidelines* from here forward) for eligibility criteria and other information (found xxxxx). Participants who become eligible based on Door 3, 4, or 5 of the Michigan Medicaid Nursing Facility Level of Care Determination must be informed that eligibility for continued services may be short term only.

PROVIDING PROGRAM INFORMATION . . .

INFORMATION ABOUT SPECIFIC PROGRAMS AVAILABLE IN THE APPLICANT'S GEOGRAPHIC LOCATION OR CONTACT INFORMATION FOR COMMUNITY REFERRAL AGENCIES MUST BE PROVIDED

When the consumer states an interest in community options, the provider must inform the individual about specific community programs or provide information about agencies that provide such information. The Access Guidelines will provide basic information that is applicable across the state of Michigan.

DOCUMENTING ALTERNATIVES . . .

SPECIFIC ALTERNATIVE INFORMATION IS PROVIDED

Section Two of the Freedom of Choice form confirms that the applicant has received written information regarding appropriate local programs. The written information must include the type of program, eligibility requirements, and contact information for the region.

SETTINGS OF CARE . . .

OPTIONS FOR, AND INFORMATIONAL ACCESS TO, THE MOST INTEGRATED SETTING OF CARE

A critical aspect of Michigan's Informed Choice Process (Freedom Of Choice form) is to ensure that applicants understand their options and that they have ongoing access to information about all settings and programs. As the functional ability of participants may improve over time, it is important to continue to update their options and discharge plan. Guidelines for discharge planning are included in later sections and in the Access Guidelines.

APPLICANT IS NOT DETERMINED FUNCTIONALLY/MEDICALLY ELIGIBLE . . .

ADVERSE ACTION NOTICE AND REFERRAL INFORMATION PROVIDED

When the applicant fails to qualify under the Michigan Medicaid Nursing Facility Level of Care Criteria, the provider must issue an adverse action notice and refer the applicant to appropriate local agencies for assistance. The provider should rely on the Access Guidelines (found xxxxx) for program eligibility criteria and other information. The applicant's Freedom Of Choice form must be kept on file for three years.

PERSON-CENTERED PROCESSES

MDCH requires a person-centered approach to care planning for the three programs noted above. Such an approach empowers participants to define the direction for their life. During the planning process, care plan facilitators must immediately seek to understand the interests and chosen life conditions of the participant. The resulting care plan must be consistent with identified and documented personal goals. During the ongoing planning process, it is essential to discover evolving participant wishes in regard to advance planning, ethnic and cultural issues, and overall goals for living.

Person-centered planning requires that it is the individual who defines what is meaningful in life and what really matters most. All participants must have the opportunity to make informed choices and exercise control to the fullest extent possible. Sometimes, they must be supported by others (legal guardians, designated representatives, program staff) in this process.

Evidence of Person-Centered Care Planning must be demonstrated through the following:

- The medical record must include the following:
    - care plans that clearly document participant strengths and skills and chosen interventions to foster these abilities, as well as participant stated goals for care.
    - evidence through progress notes and care planning documents that the participant fully and actively participates in making the decisions that affect quality of life. Planning strategies and resources must be consistent with the desired outcomes and needs of the participant.
    - documented planned interventions acknowledging a participant's cultural background issues when they affect the planning and decision-making process.
    - evidence through progress notes and care planning documents that the participant expresses their preferences if they choose during the person-centered planning process with the support of family, friends, and staff if necessary.
    - documentation that the participant chose whether or not other persons should be involved in the person centered planning process.
    - documentation that the participant chose their desired care outcomes, and care givers whenever possible.
    - evidence that the participant's preferences and outcomes were seriously considered and, in situations where it was difficult to implement their planned interventions, the team arrived at a compromise acceptable to the participant.

- The care plan must remain current at all times. Interventions must be monitored on an ongoing basis for their effectiveness in achieving the outcomes identified by the participant. These are critical elements since goals and preferences are constantly evolving. It is important to keep asking questions, listening and discovering the preferences of the participant.

- Quality improvement plans must include systems for feedback from the participants and their families regarding the opportunities they have to express needs and preferences and the ability to make choices.

NURSING REHABILITATIVE/RESTORATIVE CARE

Applicants who qualify for Nursing Facility Level of Care Programs through Door 3, Door 4, or Door 5 of the Michigan Medicaid Nursing Facility Level of Care Determination may have unstable medical conditions with short-term support needs. Applicants who do not qualify through any of the remaining Doors, but only under Door 3, Door 4, or Door 5 alone or in combination, must be provided an active plan of care that includes restorative nursing care and a discharge plan (except for those receiving end-of-life care).

A care plan for those with unstable conditions must include interventions that promote the ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial function.

Restorative nursing therapy services do not require a physician's order. Services should focus on maintenance of function and skill practice in such activities as walking and mobility, dressing and grooming, eating, swallowing, transferring, amputation care and communication.

Nursing interventions that assist or promote the participant's ability to attain their maximum functional potential must be included in the care plan. Nursing restorative care does not include procedures carried out under a skilled therapist. A rehabilitative/restorative care plan must meet all the following criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic re-evaluation of current ability and progress by a licensed practical nurse or registered nurse must be present in the clinical record. Appropriate revisions to the care plan must be made.
- Nurse assistants or personal care workers must be trained in the techniques that promote the participant's involvement in the activity.
- Activities are carried out or supervised by members of the nursing staff. Under licensed nurse supervision, other staff and volunteers will be assigned to work with specific participants.
- Nursing Rehabilitative/Restorative Care does not include exercise groups with more than four participants per supervising helper or caregiver.

NURSING REHABILITATIVE/RESTORATIVE CARE INTERVENTIONS

Range of motion (passive) exercises are passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point through the participant's available range of motion. The participant provides no assistance. These exercises must be planned, scheduled, and documented in the clinical record. Helping a participant get dressed does not, in and of itself, constitute a range of motion exercise session.

Range of motion (active) exercises are performed by a participant, with cueing or supervision by staff that is planned, scheduled and documented in the clinical record. When participants do most of the modality, but need some assistance with the final stretch, it is still considered active range of motion.

Splint or brace assistance includes two types:

1) staff provide verbal and physical guidance and direction that teaches the participant how to apply, manipulate, and care for a splint or brace, or
2) staff have a scheduled program of applying and removing a splint or brace, assessing the participant's skin and circulation under the device, and repositioning the limb in correct alignment.

These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice are activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

- **Bed mobility** - Activities used to improve or maintain participant self-performance in moving to and from a lying position, turning from side to side, and positioning, either with or without assistive devices.
- **Transfer** - Activities used to improve or maintain participant self-performance in moving between surfaces or planes, either with or without assistive devices.
- **Walking** - Activities used to improve or maintain participant self-performance in walking, either with or without assistive devices.

- **Dressing or grooming** - Activities used to improve or maintain participant self-performance in dressing/undressing, bathing/washing, and performing other personal hygiene tasks, either with or without assistive devices.

- **Eating or swallowing** - Activities used to improve or maintain participant self-performance in feeding oneself food/fluids, or activities used to improve or maintain the participant's ability to ingest food/fluids by mouth, either with or without assistive devices.

DISCHARGE POTENTIAL AND DISCHARGE PLANNING

All participants in Michigan Medicaid Long Term Care Programs must be evaluated to determine that the proposed program best meets the participant's needs. Participants who qualify only under Door 3, 4 or 5 (alone or in combination) may have greater potential for discharge from the program or setting. Some participants may be recuperating from an acute health condition and have associated functional needs. These participants may only require services for a limited time.

Since the need for nursing facility level of care may be limited for these participants, providers are required to maintain an active discharge plan and ongoing review process for these potentially short-term participants.

During initial assessment, specific barriers to returning to the community or a less intense program must be identified. Such an assessment should include (but not be limited to) the following:

- Presence of available housing
- An evaluation of informal community support
- Ability for self care

The medical record must include the following documentation:

- The participant's discharge planning goals
- An assessment of specific barriers to achieving goals
- Interventions specifically developed to address discharge needs
- Monthly progress toward eliminating the identified barriers must be documented

Michigan Department of Community Health

Nursing Facility Level of Care Exception Process

The following guidelines describe the second level review criteria for those applicants who did not meet the Michigan Medicaid Nursing Facility Level of Care Determination through the electronic web-based form. These criteria are used by the Michigan Department of Community Health (MDCH) or its designee on a provider's request to evaluate long term care program needs and appropriateness for Medicaid-reimbursed nursing facility care, the MI Choice Program, or the Program of All Inclusive Care for the Elderly (PACE).

Applicants who exhibit the following characteristics and behaviors may be admitted to programs requiring the Nursing Facility Level of Care definition.

Frailty

The applicant has a significant level of frailty as demonstrated by at least one of the following categories:

- Applicant performs late loss ADLs (bed mobility, toileting, transferring, and eating) independently but requires an unreasonable amount of time
- Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity
- Applicant has experienced at least two falls in the home in the past month
- Applicant continues to have difficulties managing medications despite the receipt of medication set-up services
- Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services
- Applicant meets criteria for Door 3 when emergency room visits for clearly unstable conditions are considered

Behaviors

The applicant has at least a one month history of any of the following behaviors, and has exhibited two or more of these behaviors in the past seven days:

- Wandering
- Verbal or physical abuse
- Socially inappropriate behavior
- Resists care

Treatments

The applicant has demonstrated a need for complex treatments or nursing care

Michigan Department of Community Health
Michigan Medicaid Nursing Facility Level of Care Determination
Telephone Intake Guidelines

1. In the past seven days, has the person had any difficulty with transferring from bed to chair, toileting, eating, or moving around in bed?

   Yes, the applicant needs assistance with at least one of these activities.

   No, the applicant does not need assistance in any of these activities.

If yes, the applicant qualifies for an assessment.

2. In the past seven days, has the applicant had any difficulty with daily decisions

   Yes, the applicant experienced some difficulty making decisions, or decisions were poor or did not make decisions.

   No, the applicant made decisions that consistently maintained safety and quality of life without difficulty.

If yes, the applicant qualifies for an assessment.

3. In the past seven days, has the applicant had difficulty remembering things significant to daily life? Does the applicant have difficulty remembering to take medications as prescribed?

   Yes, memory problem and lives alone

   No

If yes, the applicant qualifies for an assessment.

4. In the last 14 days, has the applicant seen the physician with any medication order changes? This does not include a routine maintenance visit.

Yes, the applicant has been examined by a physician, or had an emergency room visit, more than once in 14 days with order changes for unstable medical conditions.

No, the applicant has seen the physician for routine matters or not at all.

If yes, the applicant qualifies for an assessment.

5. Is the person currently being treated for any of the following conditions

Condition	Self Report of stability	Additional Qualifications
Heart Disease/high blood pressure	Unstable	With associated shortness of breath and on minimal exertion or with IADL/ADL needs
Diabetes	Unstable	2 recent insulin order changes
Arthritis	Unstable	With associated IADL and ADL needs; and two arthritis medications
Pneumonia		With associated IADL/ADL needs
End of Life Care (life expectancy less than 6 months)		None
Cancer		With associated IADL/ADL needs
Other Serious Conditions	Unstable	With associated IADL/ADL needs

If yes for any of the conditions above, and self-reports instability for indicated conditions, and reports IADL/ADL needs for indicated conditions, the applicant qualifies for an assessment.

6. What treatments is the person receiving?

Stage 3-4 pressure sores	Yes	No
Intravenous or parenteral feedings	Yes	No
Intravenous medications	Yes	No
Daily oxygen therapy	Yes	No
Daily Tracheostomy care/suctioning	Yes	No
Daily insulin with 2 order changes in last two weeks	Yes	No
Kidney dialysis	Yes	No
Other significant treatments	Yes	No

If yes for any of the above, the applicant qualifies for an assessment.

7. Has the person been scheduled to receive or is receiving Speech, Occupational, or Physical Therapy?

   Yes

   No

If yes, the applicant qualifies for an assessment.

8. Has the person had any problems with any of these behaviors in the past seven days

Wandering	Yes	No
Verbal or physical abuse	Yes	No
Socially inappropriate behavior	Yes	No
Resists Care	Yes	No
Hallucinations	Yes	No
Delusions	Yes	No

If yes for any of the above, the applicant qualifies for an assessment.

9. Has the person experienced more than one fall in the past month?

   Yes

   No

If yes, the applicant qualifies for an assessment.

ACCESS GUIDELINES TO STATE SERVICES FOR PERSONS WITH LONG TERM CARE NEEDS

SECTION 1 - INTRODUCTION

1.1 Purpose of this Document

This document is a tool developed for use by Long Term Care Providers in Michigan to aid them in making appropriate referrals for persons who approach them for Long Term Care services. The guidelines should serve as a starting point for locating applicable statewide and local services for a wide range of personal needs.

1.2 How to Use the Access Guidelines

The *Access Guidelines* describe services relevant to persons with Long Term Care needs from three main public agencies:

- Michigan Department of Community Health – Long Term Care (LTC) Services
- Family Independence Agency (FIA)
- Michigan Department of Community Health – Mental Health and Substance Abuse Administration

The contents of the guide are broken down for each agency into the following sections:

Overview of Services	Provides a simple overview of services offered.
Description of Services	Information about services provided.
Contacting the Office or Service Provider	Information on how to get in touch with an agency, how to address special communication needs and information on transportation services. Blanks are included for notation of specific contact information for local resources.
Determination of Needs and Eligibility	Explains the process of determining eligibility for services and identifying the individual needs.
Decision Tree	A figure that graphically depicts the beginning of the eligibility determination process.
How to Appeal a Determination	Provides information on how to begin the appeal process if there is disagreement on determination of eligibility or services provided.

Each of the public agencies discussed in the *Access Guidelines* will share information regarding a person with other agencies or organizations if the person or legal guardian has signed a release of information form.

In addition to these public agencies, there may be many local and community resources that can provide information and services to persons. Some of these agencies and organizations are described in Section V of this document.

Advocacy organizations can help persons determine the services for which they qualify. An advocate can be a family member, friend or neighbor, but occasionally the need for help from an organization that specializes in advocacy services or a lawyer may be necessary. A social worker, case manager or minister may also be able to help with advocacy needs. Centers for Independent Living (CILs), Legal Aid Services, Protection and Advocacy Services, and the United Way are among many organizations that can help persons find needed advocacy services. Organizations are described in more detail in Section V of this document.

1.3 To Obtain Additional Copies and Find More Information

- **Access Guidelines may be downloaded from the website:**
- **Printed copies may be ordered from: [address]**

The Guidelines should be used in conjunction with the OSA Resource Directory maintained by the Office of Services to the Aging (OSA), and available online at: http://www.miseniors.net. The OSA Resource Directory allows for web-based searches for service providers by area of need, agency name, and geographic location.

SECTION 2 - MICHIGAN DEPARTMENT OF COMMUNITY HEALTH - LONG TERM CARE PROGRAMS

2.1 Michigan Department of Community Health (MDCH) – Long Term Care (LTC) Programs

Long Term Care services are not provided directly by MDCH. Rather, Michigan Medicaid will provide payment to cooperating agencies or organizations for long term care services based on the medical need or functional limitations of the person applying for services. MDCH staff can assist with initial information and referral in many cases, but persons seeking specific LTC services should be referred to the contacts listed below.

FIA determines Medicaid eligibility. (Refer to Section III for information on FIA Eligibility Determination Services.)

2.2 Overview of LTC Services

	Eligibility	Contact
Home and Community Based Services		
• Home Health	Medical criteria/Physicians order	Primary Care Physician or Home Health Agency
• Home Help	Must have a functional limitation	FIA Office - Adult Services Unit
• Physical Disability Services (PDS)	Must meet medical criteria	FIA Office - Adult Services Unit
• MI Choice Waiver	Over 18 & meet nursing facility level of care	Waiver Agent or Local Area Agency on Aging
• Program for All-Inclusive Care for the Elderly (PACE)	Must meet medical/age/ geographic criteria	Henry Ford Health System-Center for Senior Independence
Residential Services		
• Adult Foster Care	Over 18	FIA Office - Adult Services Unit
• Homes for the Aged	Over 60	FIA Office - Adult Services Unit
Nursing Facilities		
	Must need nursing facility level of care	Individual facility or www.michigan.gov/cis
Hospice		
	Must be near the end of life	Local Hospice agency or www.mihospice.org

2.3 Informed Choice

The concept of informed choice is at the heart of the Michigan Department of Community Health admission process for long term care services. It is essential that program applicants and/or their representatives fully understand all available options under Medicaid.

Medicaid-reimbursed nursing facility care, the MI Choice Program for Elderly and Disabled, and PACE must utilize equivalent functional/medical eligibility criteria as stated by federal law (Social Security Act, Sections 1915c, 1919a, and 1934).

When qualifying for any one of these programs, applicants will automatically meet the functional/medical eligibility criteria for all three programs. When programs are open to new enrollment, the MDCH wants to ensure that applicants are afforded the opportunity to make an informed choice about where their needs can best be met.

Michigan's Informed Choice Process ensures that information, education, and referral systems are available and working to provide the opportunity to make such informed choices. Each of the above program entry points are required to make pertinent information available to each potential participant.

2.4 Beginning the Process - Determination of Functional/Medical Eligibility

MDCH requires use of an electronic web-based tool to determine functional/medical eligibility for programs required to use the nursing facility level of care criteria. The end result of this electronic system is a document titled "Freedom of Choice." The electronic system automatically identifies the applicant and the functional/medical eligibility determination and documents this information on the Freedom of Choice form (which can be found with the Michigan Medicaid Nursing Facility Level of Care Determination in the Forms Appendix and website at xxxxxxx). Applicants who do not meet the eligibility criteria have the option to request a review from MDCH or its designee.

2.5 Applicant Determined Functionally/Medically Eligible

Upon determination of functional/medical eligibility, the provider must explain all three program options to the applicant, as well as other Medicaid and community programs when appropriate. Participants who become eligible based on Door 3, 4, or 5 of the Michigan Medicaid Nursing Facility Level of Care Determination must be informed that eligibility for continued services may be short term only.

2.6 Providing Program Information

Information about specific programs available in the applicant's geographic location or contact information for community referral agencies must be provided.

When the person states an interest in community options, the provider must inform the person about specific community programs or provide information about agencies that provide such information. The Access Guidelines will provide basic information that is applicable across the state of Michigan.

2.7 Documenting Alternatives

Specific alter***n***ative information is provided. Section Two of the Freedom of Choice form confirms that the applicant has received written information regarding appropriate local programs. The written information must include the type of program, eligibility requirements, and contact information for the region.

2.8 Settings of Care (Options and Informational Access to the Most Integrated Setting of Care)

A critical aspect of Michigan's Informed Choice Process (Freedom Of Choice form) is to ensure that applicants understand their options and that they have ongoing access to information about all settings and

programs. As the functional ability of participants may improve over time, it is important to continue to update their options and discharge plan. Guidelines for discharge planning are included in later sections and in the Access Guidelines.

2.9 Applicant is Not Determined Functionally/Medically Eligible

When the applicant fails to qualify under the Michigan Medicaid Nursing Facility Level of Care Determination, the provider must issue an adverse action notice and refer the applicant to appropriate local agencies for assistance. The provider should rely on the Access Guidelines (found xxxxx) for eligibility criteria and other information. The applicant's Freedom Of Choice form must be kept on file for two years.

2.10 Home and Community Based Services

2.10.A. Description of Home and Community Based Services

Home and Community Based Services are provided to enable persons who need some level of assistance to remain in their home. The need for services may range from help with household chores to nursing facility level of care.

2.10.B. Home Health

Skilled nursing care is provided by a registered nurse, and at times, personal care is provided by a home health aide.

2.10.C. Home Help

Home Help provides unskilled hands-on assistance with personal care such as help preparing meals, eating, grooming, and moving around the home.

2.10.D. Physical Disability Services (PDS)

PDS provides assistance purchasing durable medical equipment and home modifications not otherwise covered by Medicaid.

2.10.E. MI Choice Waiver

Support is provided for services and personal care that allow an person to remain in their home. Covered services include homemaker and chore services, home-delivered meals, adult day care, modifications to the home, specialized equipment or medical supplies, counseling and respite care.

2.10.F. PACE

The PACE program provides primary, rehabilitative, and personal care services to those over the age of 55. Currently, the PACE program is only available in parts of Wayne County.

2.10.G. Contacting the Service Provider

Home Health	To learn more about Home Health, a person should ask their primary care physician, or contact a Home Health Agency directly
Home Help	Eligibility for Home Help is determined through FIA. A person can locate their local FIA office in the telephone book, or visit www.michigan.gov/fia.
Physical Disability Services (PDS)	Eligibility for PDS is determined through FIA. A person can locate their local FIA office in the telephone book, or visit www.michigan.gov/fia.
MI Choice Waiver	MI Choice Waiver services are offered through Waiver Agency Offices. Call the Local Area Agency on Aging for information..

PACE	Call 313-874-7205.

Local FIA Office:

Phone Number:

Address:

Local MI Choice Waiver Agent:

Phone Number:

Address:

2.10.H. Determination of Needs and Eligibility

Once a person is determined to be Medicaid eligible, a formal assessment is conducted by a trained professional to determine the person's individual level of need for Home and Community Based Services. Each program determines eligibility differently.

Home Health	The person must meet medical criteria or have a physician's order.
Home Help Services	Persons must have a functional limitation in an activity of daily living.
Physical Diability Services (PDS)	Persons must have a medical need.
Mi Choice Waiver	Persons must be over 18, meet nursing facility level of care and must require one of thirteen waiver services.
Pace	Persons must be aged 55 or older, live in the service area, and meet nursing facility level of care criteria.

The eligibility determination may take up to 45 days for all Home and Community Based Services. Interim services, pending Medicaid eligibility, are not provided for any of the home and community based programs, except for MI Choice Waiver. Services for MI Choice Waiver will be provided if the applicant is potentially Medicaid eligible, but will be terminated if the applicant is determined to be financially non-eligible for MI Choice Waiver.

Some programs allow beneficiaries to hire family members or friends. Contact the program for more information.

2.11 Residential Services

2.11.A. Description of Residential Services

Residential facilities provide supportive services for persons who need assistance with daily living, such as bathing or medication reminders, but do not need intense medical supervision. Medicaid will pay for services at either a licensed or non-licensed facility for eligible persons. There are two types of licensed assisted living facilities:

- Adult Foster Care – A living situation where room, board, personal care and supervision for persons over 18 years of age are provided.
- Homes for the Aged – A living situation where room, board, personal care and supervision for persons over 60 years of age are provided.

2.11.B. Contacting the Service Provider

For a list of licensed facilities, visit www.michigan.gov/cis. Services may vary among facilities; a facility should be contacted directly to learn which services are offered.

2.11.C. Determination of Needs and Eligibility

To receive funding for Residential Services, a person must be Medicaid or SSI eligible. Admission criteria will vary among each assisted living facility.

The following documentation and information may be requested to determine eligibility: medical condition, demographics, functional ability, medications, support system and other services received. For the MI Choice Waiver, income and asset information for Medicaid eligibility will also be required.

2.12 Nursing Facilities

2.12.A. Description of Nursing Facility Services

A nursing home is a residence that provides housing, meals, nursing and rehabilitative care, medical services, and protective supervision for post acute and long-term needs. It also provides daily living and recreational activities to residents. Nursing homes are licensed, and most are certified by the State to provide various levels of care, which range from custodial care to skilled nursing care.

2.12.B. Contacting the Service Provider

Nursing facilities across Michigan offer a range of services. To find a home in a specific area, or who provides specialized services, visit www.michigan.gov/cis. When contacting a nursing facility, a person should ask to talk to someone from admissions for information regarding the facility, and to request a tour. Online websites will provide guidance on how to select the most appropriate facility. One such website is http://seniors-site.com/nursingm/select.html.

Local Area Agencies on Aging have information on nursing facilities by geographic area or specialty. To find contact information for local AAAs, visit www.miseniors.net, or call the Michigan Office of Services to the Aging (OSA) at 1 - (517) 373-8230. Contact information for local Area Agencies on Aging Offices is also located in the business pages of the phone book.

2.13 Determination of Needs and Eligibility

Eligibility is determined by medical need and a physician's order. The following documentation and information may be requested to determine eligibility: medical condition, demographics, functional ability, medications, support system and other services received.

Medicaid will pay for nursing facility care for eligible persons. Interim services are provided if a person is waiting for Medicaid eligibility determination, but the person may be responsible to pay for their stay if Medicaid is not approved.

2.14 Discharge Planning

All participants in Michigan Medicaid Long Term Care Programs must be evaluated to determine that the proposed program best meets individual needs. Some program participants may have greater potential for discharge from the program or setting. Some participants may be recuperating from an acute health condition and have associated functional needs. These participants may only require services for a limited time.

Since the need for nursing facility level of care may be limited for these participants, providers are required to maintain an active discharge plan and ongoing review process for these potentially short-term participants.

Persons should expect early identification of individual barriers to returning to the community or a less intense program must be identified. Such an assessment should include (but not be limited to) the following:

- Presence of available housing
- An evaluation of informal community support
- Ability for self care

2.15 Hospice

2.15.A. Description of Hospice Services

Hospice services include skilled care, personal care, pain management, counseling and family support for people at the end of life and their families. Hospice services are typically rendered in the home, but may occasionally be provided in a residential facility.

2.15.B. Contacting the Service Provider

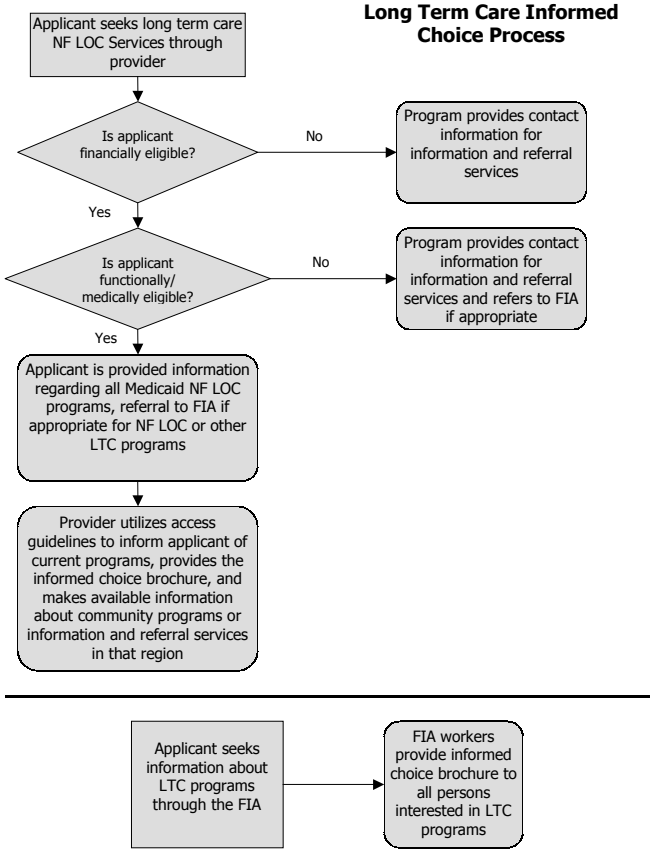
When calling a hospice agency, ask for an intake person. Hospice workers will travel to the person's residence.

2.15.C. Determination of Needs and Eligibility

A statement from a physician showing that the person is expected to die within six months is necessary to receive hospice services. A formal assessment is done to determine a person's needs.

Eligibility determination and provision of hospice services typically takes place very quickly, and interim services are provided while waiting for eligibility determination. A caseworker will be assigned to the person at the beginning of the application process.

Figure 1: Michigan Medicaid Long Term Care Informed Choice Process



2.16 How to Appeal an LTC Determination

If a person does not agree with his eligibility determination, he can appeal the decision. Because LTC is not a direct service provider, a denial notice should be requested from the agency to which application was made. The denial notice will list the appeal rights for the program in question. Having an advocate is recommended throughout the application process. If a person is deemed ineligible to receive services, a person may reapply for services when his situation has changed and the eligibility criteria will be met.

For Hospice: If services are denied, a person or representative on behalf of the person, may reapply as soon as they receive the necessary information from a physician. If a person does not agree with a determination, the person will need to request a hearing and follow the appeals process for Medicare and Medicaid.

SECTION 3 – FAMILY INDEPENDENCE AGENCY

3.1 Family Independence Agency (FIA) – Overview of Services

Family Independence Agency Services	**Eligibility**	**Contact**
Adult Services		
<Independent Living Services	None – Information and referral available to anyone. There are no public resources to pay for services.	Local FIA Office-Adult Services Unit
<Home Help Services	Must be Medicaid eligible with a functional limitation-no age requirement	Local FIA Office-Adult Services Unit
<Adult Community Placement	Must be Medicaid eligible and meet age requirements	Local FIA Office-Adult Services Unit
<Adult Protective Services	None	Local FIA Office-Adult Services Unit
< Physical Disabilities Services	Must be Medicaid eligible, have an open case with adult services, have a documented medical need and no other coverage	Local FIA Office-Adult Services Unit
Eligibility Determination		
<Medicaid (MA) (Includes MI Child & Healthy Kids)	Low income/assets	Local FIA Office-Medicaid Eligibility
<Adult Medical Program	Single Adult not on Medicaid, low income/asset requirements also	Local FIA Office-Medicaid Eligibility
<State Disability Assistance	Check with local FIA Office	Local FIA Office-Medicaid Eligibility
<Family Independence Program (FIP)	Income, asset and family composition	Local FIA Office-FIP Staff
<Food Assistance/Bridge Card	Income and asset criteria	Local FIA Office-FIP & ES Staff

3.2 Description of FIA Services

3.2.A. Adult Services

Independent Living Services	FIA providers services to enhance independence and self-sufficiency.
Home Help Services	This is an in-home program to assist with activities of daily living to enable a person to remain in an independent living situation.
Adult Community Placement Services	This program assists persons with making informed decisions about out-of-home living arrangements (adult foster care and homes for the aged) when independent living is not possible. A Personal Care/Supplemental payment may be available to cover some of the costs of those living arrangements if the person is on Medicaid.
Adult Protective Services	FIA staff investigate complains of abuse, neglect, and exploitation of vulnerable adults and provide linkage to needed community services.
Medical Equipment and Assistive Technology	FIA providers information about sources of medical equipment and, in some cases, can provide payment for equipment and/or services that are not covered by Medicaid through Physical Disability Services.

3.2.B. Eligibility Determination Services

FIA offices determine eligibility for the federal Medicaid insurance programs. (For a listing of all Medicaid categories and unique non-financial eligibility factors for each category, refer to the "Medicaid Overview" in Appendix 1.)

Medicaid	Persons qualifying for Supplemental Security Income (SSI) are automatically eligible for Medicaid. Persons who might qualify for SSI should be referred to Social Security Administration.
Adult Medical Program	FIA determines eligibility for the Adult Medical Program, which may cover basic medical care to single lower income persons between the ages of 21 and 65.
State Disability Assistance (SDA) Program	FIA determines eligibility for the SDA Program through which a person can receive a monthly grant. The person must be determined to have a disability that is expected to last at least 90 days but not more than one year.
Family Independence Program (FIP)	FIP provides financial assistance to families with children. The goal of FIP is to maintain and strengthen family life for children and the parents or other caretaker(s) with whom they are living, and to help the family attain or retain capability for maximum self-support and personal independence.
Food Assistance Program (FAP)/Bridge Card	The purpose of this program is to raise the food purchasing power of low-income persons. Benefits are issued using electronic technology and a debit card known as the Bridge Card.

3.3 Contacting the Office

Persons should call their local FIA office listed in the phonebook under “State Government” or “County Government” and ask for the Adult Services Unit, or visit the website: http://www.michigan.gov/fia. An Adult Service worker will be able to refer callers to the appropriate person. An FIA worker may be assigned to work with the person at that time. Any applicant has the right to bring with them an advocate to assist in the application process.

Text telephone (TTY) technology is available in all FIA offices to address any speech impairments. FIA staff can make home visits and may arrange for transportation to medically required appointments for persons who are medically eligible.

Local FIA Office, Adult Services Unit:

Phone Number: _____

Address: _____

_____

_____

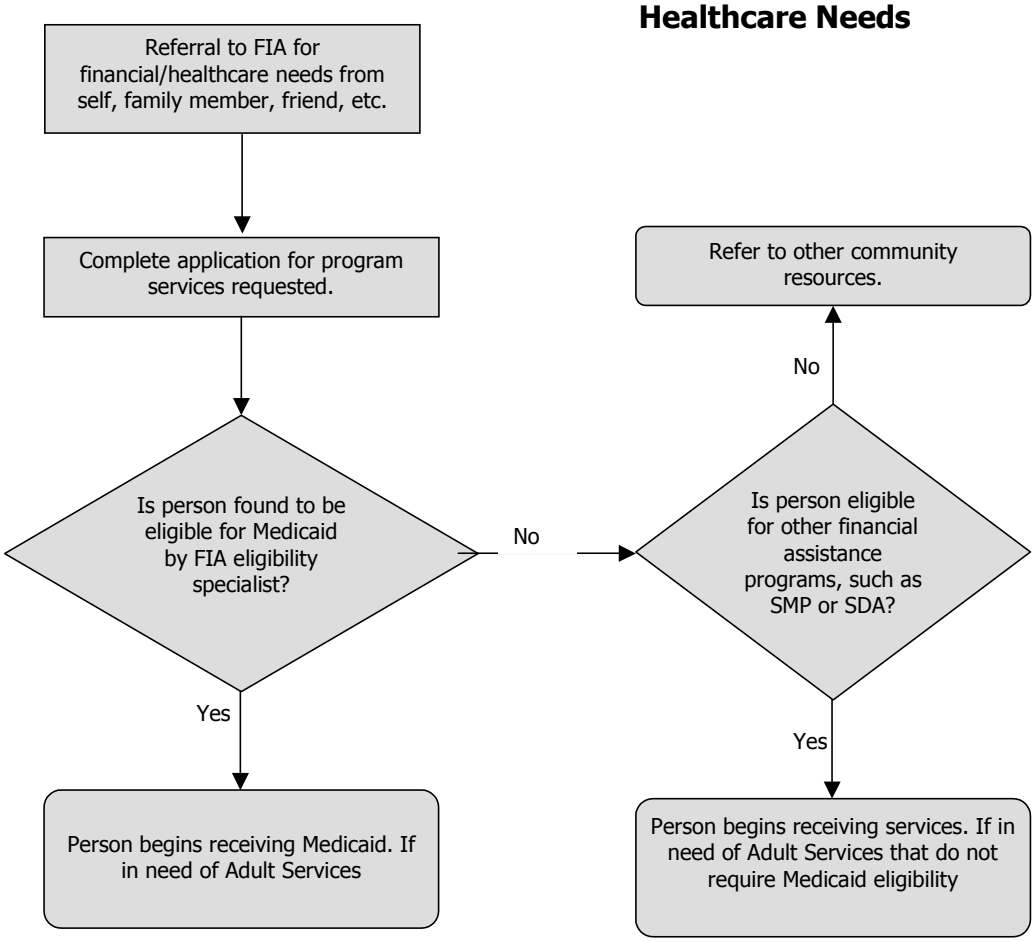
3.4 Determination of Needs and Eligibility

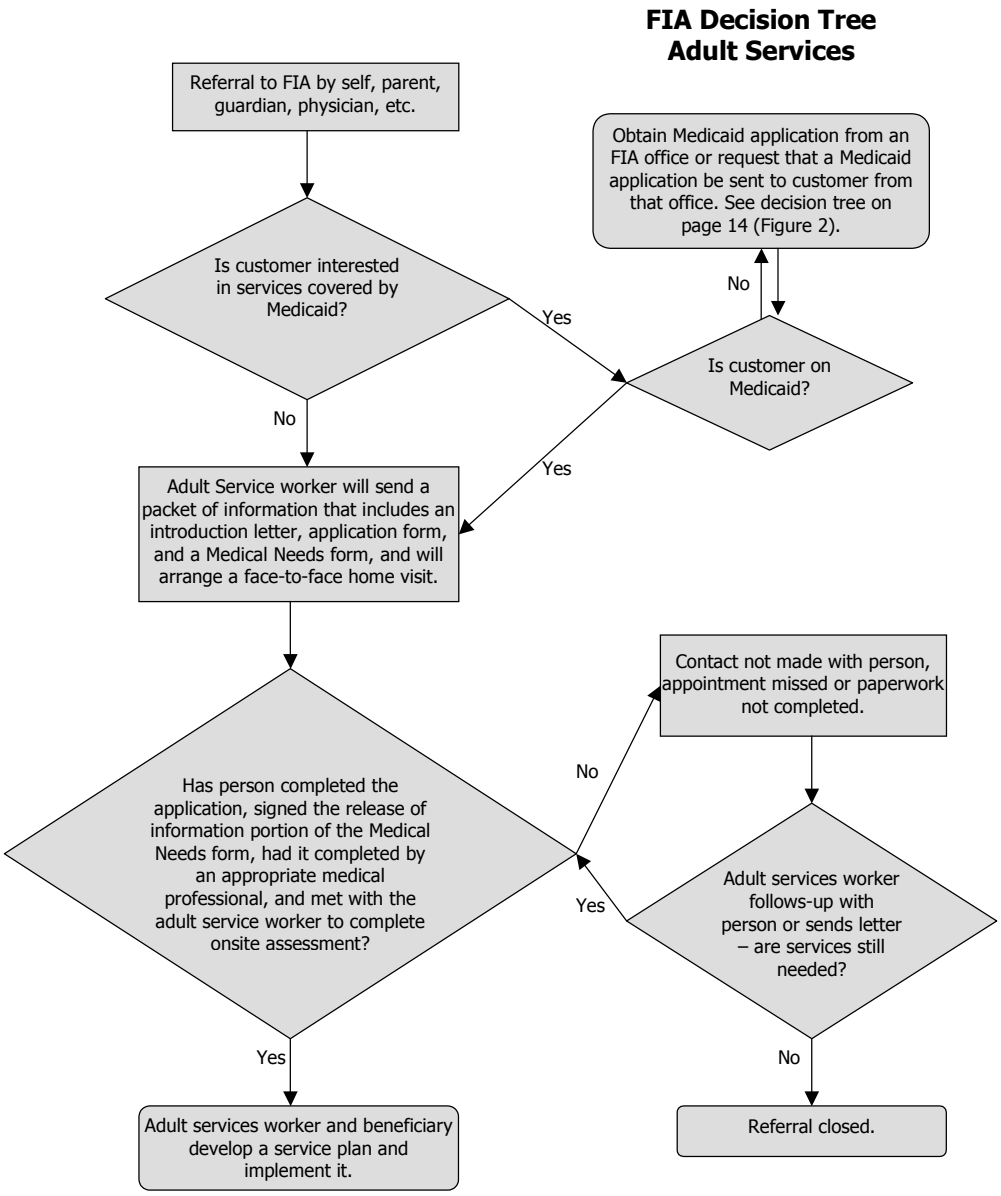
An FIA caseworker is provided to assist with determining eligibility for Medicaid and other financial programs; an FIA case manager is provided to assist with eligibility determination for adult and child services programs. Persons should call a local FIA office and ask whom to speak to about eligibility determination, as processes can vary from one FIA office to another.

Eligibility criteria for each FIA service are different. Eligibility is based on such factors as income, assets, health and/or living situation. Because staff in local FIA offices are specialized and cover financial and Medicaid (and State Medical) programs as well as other services, it is best if the person asks for the program they are interested in by name. This is especially important in the larger FIA county offices that have multiple locations, each of which may not cover all available services in that county. Persons should call the main phone number for their county FIA to find out which office offers the program in which they are interested. Documentation needed to determine eligibility and needs may vary for each program that FIA offers.

A formal assessment will be conducted by FIA staff to determine the needs of each person. Eligibility for most FIA programs must be determined in 30-60 days.

FIA Decision Tree Support for Financial/ Healthcare Needs





3.4.A. How to Appeal an FIA Determination

Persons may reapply for services any time they feel their situation has changed to make them eligible. An advocate can be helpful from the point of application to clarify an applicant's wishes and help to obtain necessary eligibility documentation.

Every FIA participant has the right to request a hearing if they feel that services and/or funding were denied or reduced inappropriately. Information on how to request a hearing is part of the official notification letter of denial or reduction.

Hearings involving Medicaid issues are handled by the Administrative Tribunal of the Michigan Department of Community Health (MDCH). Hearings not involving Medicaid are handled by Administrative Hearings staff in the FIA Bureau of Legal Affairs. There may be multiple levels to the appeals process, including the opportunity for a review of the hearing decision.

SECTION 4 - MICHIGAN DEPARTMENT OF COMMUNITY HEALTH – MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION

4.1 Community Mental Health Services Programs (CMHSP) – Overview of Services for Children and Adults

Community Mental Health Services	**Eligibility**	**Contact**
Case Management	Severity and Income/Asset Criteria	Local CMHSP
Individual/Family/ Group Therapy	Severity and Income/Asset Criteria	Local CMHSP
Medication Administration and Review	Severity and Income/Asset Criteria	Local CMHSP
Crisis Intervention Services	Severity and Income/Asset Criteria	Local CMHSP
Applied Behavioral Services	Severity and Income/Asset Criteria	Local CMHSP
Mental Health Emergency Services	Severity and Income/Asset Criteria	Local CMHSP
Inpatient Psychiatric Services	Severity and Income/Asset Criteria	Local CMHSP
Assertive Community Treatment (ACT)	Severity and Income/Asset Criteria	Local CMHSP
Assessments	Severity and Income/Asset Criteria	Local CMHSP
Crisis Residential Services	Severity and Income/Asset Criteria	Local CMHSP
Enhanced Health Services	Severity and Income/Asset Criteria	Local CMHSP
Mental Health Home- Based Services	Severity and Income/Asset Criteria	Local CMHSP
OT, PT, Speech Evaluation	Severity and Income/Asset Criteria	Local CMHSP
Treatment Planning	Severity and Income/Asset Criteria	Local CMHSP
Transportation to and from Day Program	Severity and Income/Asset Criteria	Local CMHSP

4.2 Description of Community Mental Health Services

Community Mental Health Services Programs (CMHSPs) are contracted by the Michigan Department of Community Health to provide a full array of community-based support services for eligible persons and their families. While some CMHSPs may directly operate treatment programs, most CMHSPs establish a network of agencies and professionals to provide treatment services. There are a number of covered services that the CMHSPs are required to provide, including the following:

4.2.A. Case Management

Case management services assist mental health participants in gaining access to needed medical, social, educational, financial and other services. Core elements of case management include assessment, development of an individual plan of service, linking or coordination of services, re-assessment/follow up and monitoring of services.

4.2.B. Individual/Family/Group Therapy

Therapy is a treatment activity designed to reduce maladaptive behaviors, restore normalized psychological functioning and improve emotional adjustment and functioning.

4.2.C. Medication Administration and Review

Medication administration and review services are provided by a psychiatrist for the purposes of evaluating and monitoring medications and their effects.

4.2.D. Crisis Intervention Services

Crisis intervention services consist of face-to-face or phone contact with a person for the purpose of resolving a crisis or emergency situation requiring immediate attention.

4.2.E. Applied Behavioral Services

Behavioral services are actively designed to reduce maladaptive behaviors, to maximize behavioral self control, or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the person to function more appropriately in interpersonal and social relationships.

4.2.F. Mental Health Emergency Services

Emergency services offer 24-hour crisis intervention to persons experiencing a psychiatric crisis. In an emergency, persons can call the mental health 24-hour crisis line listed in the phone book under “Mental Health”. Persons with an emergency may walk into any mental health location or hospital emergency room for immediate treatment. Services available include assessment and referral, and screening for psychiatric hospitalization of Medicaid and uninsured persons.

4.2.G. Inpatient Psychiatric Services

Inpatient psychiatric services are provided around the clock in a hospital setting.

4.2.H. Assertive Community Treatment (ACT)

ACT is a comprehensive and integrated set of medical and psychosocial services provided on a one to one basis primarily in the person's residence or other community locations by a mobile multidisciplinary mental health treatment team.

4.2.I. Assessment (health, psychiatric, psychological testing)

Assessments are comprehensive evaluations of the physical, cognitive, behavioral or emotional needs/status of a person that may result in the initiation of a specific CMHSP service, additional assessment/consultation, or referral to an appropriate community resource.

4.2.J. Crisis Residential Services (short-term alternative to in-patient psychiatric services)

Intensive residential services provide a short-term alternative to inpatient psychiatric services for persons experiencing a psychiatric crisis.

4.2.K. Enhanced Health Services

Health-related services that are beyond the responsibility of the person's health plan are provided for rehabilitative purposes to improve overall health and ability.

4.2.L. Mental Health Home-Based Services

Family-focused intensive services are provided to persons and families with multiple service needs who require access to an array of mental health services.

4.2.M. Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy

OT, PT, and speech services are provided by a licensed professional or assistant to assist with achieving optimum functioning.

4.2.N. Treatment Planning

Activities associated with the development and periodic review of an individual plan of service are organized, including all aspects of person-centered planning as well as pre-meeting activities.

4.2.O. Transportation to and from Day Program

Transportation is provided to and from the person's residence, so they may participate in a covered day program or psychosocial rehabilitative program.

4.3 Contacting the Office

Contact information for local CMHSPs can be found in the yellow pages of the phone book under "Mental Health" or "County Government", or by calling Information. The Michigan Association of Community Mental Health Boards (MACMHB) also provides local CMHSP information at 1 - (517) 374-6848. If it is not an emergency, an initial screening over the phone or in person will be done to determine eligibility and, if eligible, an appointment/treatment will be arranged.

A TTY should be requested for persons with a hearing impairment. Translation will be available for those with limited English proficiency. These services must be made available to the person within 24 hours of contact.

Transportation services are specific to individual treatment agencies. The treatment agency may be able to coordinate transportation with local transportation providers. FIA is a provider for transportation to and from medically required appointments for persons who are Medicaid eligible.

Local CMHSP Offfice Phone Number:

Address: _____

_____

_____

4.4 Determination of Needs and Eligibility

Persons may qualify for CMHSP services if they have been diagnosed with a developmental disability, mental illness or substance abuse problem. Eligibility determination begins with a brief phone screening, followed by a face-to-face psychosocial assessment. Documentation and information on the presenting problem, history of problems, prior treatment and current symptoms, as well as current insurance and financial information, will be necessary to determine eligibility and needs. Residency and degree of impairment are factors considered in determining eligibility.

Typically, only one contact is necessary to determine a person's needs. Additional services such as psychological testing, psychiatric evaluation or further assessments may be required to determine diagnosis and course of treatment.

Once a person is determined to be eligible for services, an individual plan of services is developed using a person-centered planning process tailored to person needs. At that time, persons will be offered a choice of providers who are under contract with the CMHSPs. Services must be provided within 14 days of the assessment.

4.5 Eligibility Determination for Persons with a Developmental Disability

For persons older than five years of age, a developmental disability is a severe, chronic condition that meets all of the following requirements:

A) is attributed to a mental or physical impairment or a combination of physical and mental impairments

B) is manifested before the person is 22 years of age

C) is likely to continue indefinitely

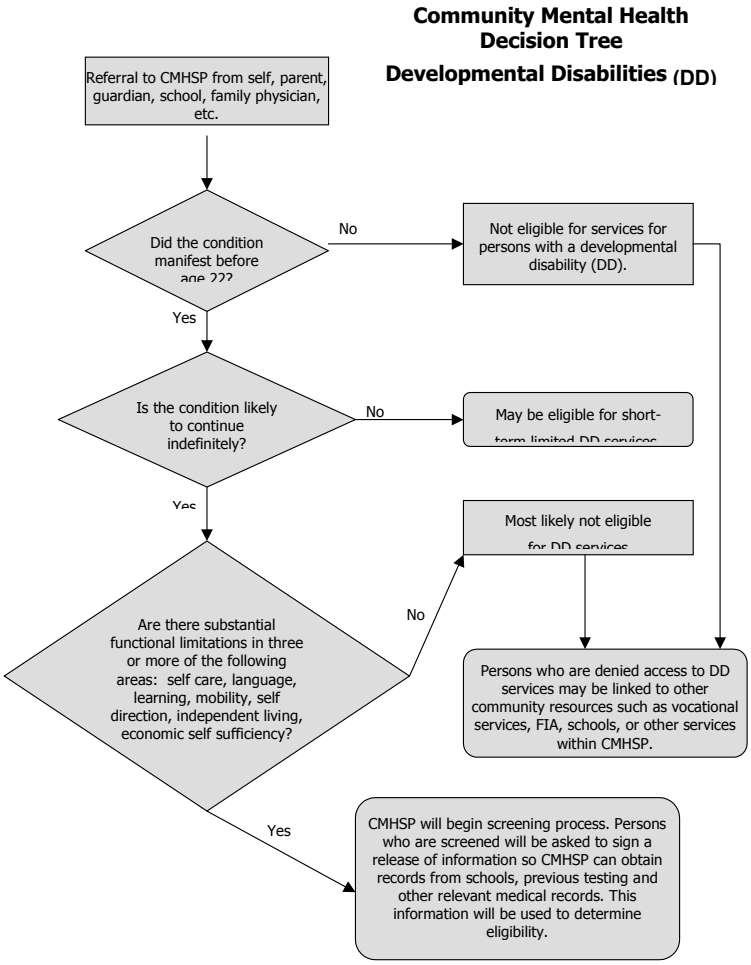
D) results in substantial functional limitation in three or more of the following areas of major life activities:

E) self care

- receptive and expressive language
- learning
- mobility
- self direction
- capacity for independent living
- economic self sufficiency

F) reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

For minors from birth to age five, a developmental disability is a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined above if services are not provided.

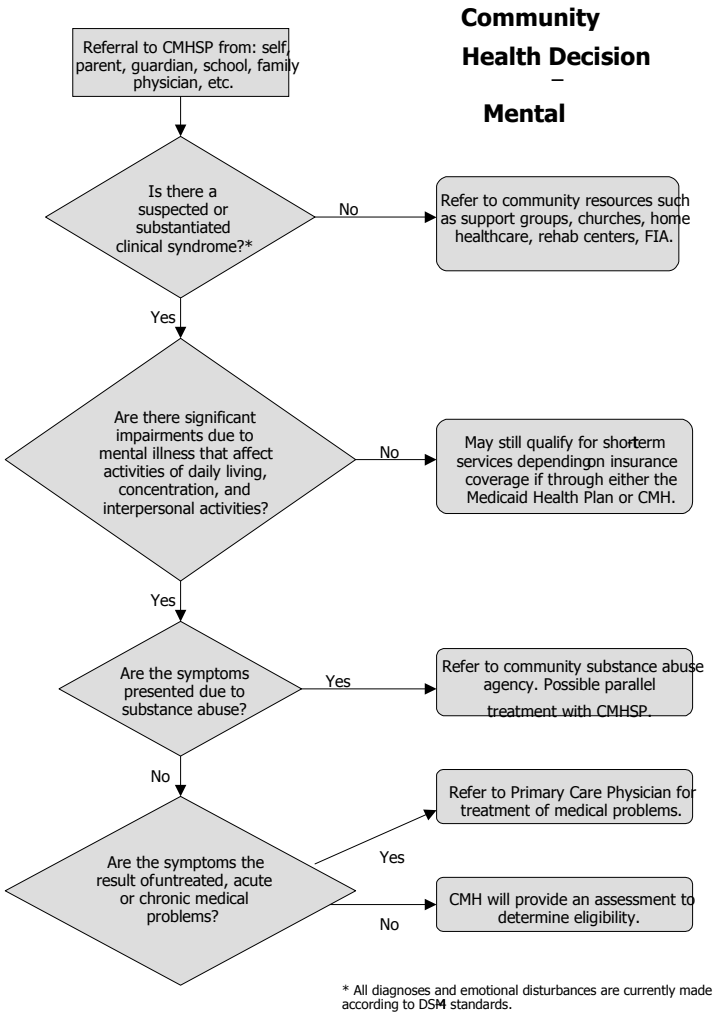


4.6 Eligibility Determination for Persons with Mental Illness

A variety of methods may be employed to make determinations regarding the presence of mental illness and any medically necessary services. The determination of medically necessary services must be based on a person-centered planning process. Co-occurring substance use disorders or underlying medical conditions should be evaluated and treated.

How mental illness affects other areas of a person's life (e.g., activities of daily living, concentration, interpersonal activities) is also considered in making the assessment of need for services.

When determining the presence and severity of mental illness, the presence of additional physical illness/medical problems or substance abuse problems needs to be considered for accurate diagnosis and effective treatment.



4.7 Substance Abuse (SA) - Access, Assessment and Referral Agencies (AAR)/Central Diagnostic and Referral Agencies (CDR)

4.7.A. Overview of Substance Abuse Services

Substance Abuse Services	Eligibility	Contact
Outpatient Services • Individual Therapy • FGroup Therapy • Family Therapy	Diagnosed substance abuse/addiction	Substance Abuse AARs or Local CMHSP
Intensive Outpatient Services	Diagnosed substance abuse/addiction	Substance Abuse AARs or Local CMHSP
Residential Services • Detoxification Services • Short-Term Residential Services • Long-Term Residential Services	Diagnosed substance abuse/addiction	Substance Abuse AARs or Local CMHSP

4.7.B. Description of Substance Abuse Services

The Michigan Department of Community Health, through its regional authorities, contracts with Access, Assessment and Referral Agencies (AARs), formerly known as Central Diagnostic and Referral Agencies (CDRs), throughout the state to provide access to alcohol and drug abuse services. AARs/CDRs provide screening and arrange for placement in appropriate services. An AAR/CDR must screen persons who receive public funding before the person may enter a treatment program. AARs/CDRs and providers focus on individual needs through person centered planning to determine treatment. Continuum of care may include:

4.8 Outpatient Services

4.8.A. Individual Therapy

Face-to-face counseling services are available for the person or his significant other.

4.8.B. Family therapy

Face-to-face counseling with the person and his significant other and/or traditional or nontraditional family members is provided.

4.8.C. Group Therapy

AARs/CDRs provide face-to-face counseling with three or more persons that can include didactic lectures, therapeutic discussions and other group- related activities.

4.8.D. Intensive Outpatient Services

Services are provided multiple days per week over a specified time period as determined by program design and the person's needs.

4.9 Residential Services

4.9.A. Detoxification

Medically supervised care is provided in a sub-acute residential setting for the purpose of managing the effects of withdrawal from alcohol and other substances. A detoxification program must be staffed 24-hours per day, seven days per week, by a licensed physician or by the designated representative of a licensed physician. Services typically last three to five days.

4.9.B. Short-Term Residential

Planned individual and/or group therapeutic and rehabilitative counseling and didactics are provided as an intense, organized, daily treatment regimen in a residential setting which includes an overnight stay. Programs have trained treatment staff supervised by a professional who is responsible for the quality of care and are typically 30 days or fewer.

4.9.C. Long-Term Residential

This professionally supervised program includes planned individual and/or group therapeutic and rehabilitative counseling, didactics, peer therapy, and rehabilitative care. The services are provided in a residential setting, include an overnight stay, and typically extend beyond 30 days.

4.10 Contacting the Office

The Michigan Resource Center [1 - (800) 626-4636] will provide local AAR/CDR office information. When calling, an electronic menu will answer. "Other Options" should be selected to talk to a person. Local information is also available in the yellow pages of the phone book under "Substance Abuse". If it is not an emergency, an initial screening over the phone or in person will be done to determine eligibility and, if

determined eligible, an appointment/treatment will be arranged. A referral will also be offered to eligible persons who walk into a location. Persons having substance related emergencies should visit the nearest emergency care unit of a local hospital.

A TTY should be requested for persons who have a hearing impairment, and translation will be available for those with limited English proficiency. TTY services must be made available to the person within 24 hours of contact.

Transportation services for meetings/appointments are specific to individual treatment agencies. The treatment agency may be able to coordinate transportation with local transportation providers.

Local Access, Assessment, and Referral Agency:

Phone Number:

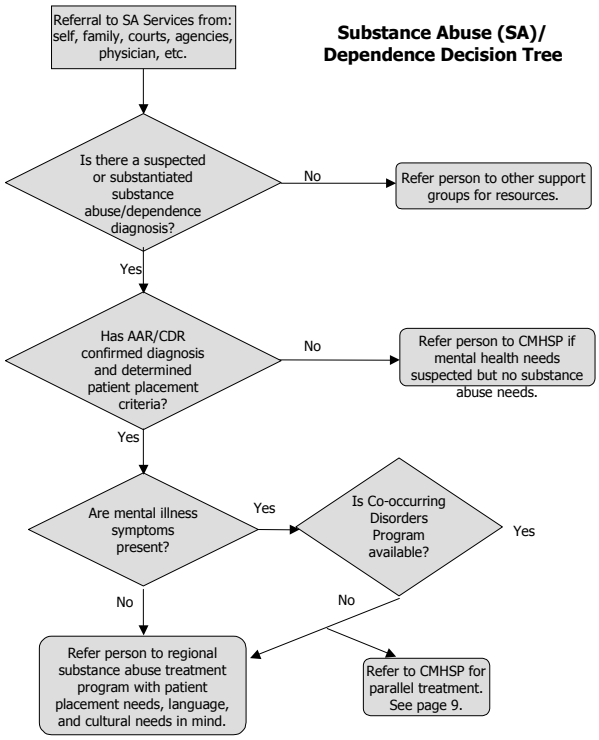
Address:

4.11 Determination of Needs and Eligibility

Individual needs are determined using standardized screening instruments and Patient Placement Criteria over the phone or in person. One or more contacts may be necessary before needs and eligibility are determined.

Eligibility requires a diagnosed substance abuse or addiction disorder and a need for publicly funded services. The person should be prepared to present documentation and information of financial status, current insurance, history of prior treatment, and current substance use as requested to determine eligibility and needs.

Eligibility is typically determined during the first phone call or interview. Service provision is based on availability and acuity of needs. If the person is in crisis while waiting for services, he should call the treating agency to receive proper care or go to the nearest emergency care unit of a local hospital.



4.12 How to Appeal a CMHSP or SA Determination

If a person or legal representative disagrees with the determination of eligibility for services, the person has the right to appeal the decision and should receive written instructions from the treating agency with the determination notification on the appeals process. A person has the right to engage an advocate or lawyer at any time during the process.

SECTION 5 – OTHER LOCAL RESOURCES FOR CARE AND REFERRAL

A number of local agencies and organizations provide services that may allow a person with long term care needs to remain in his home. This section describes some of key organizations and provides information for locating them. In addition to the agencies listed, a person's church may be able to organize services.

Local organizations may also serve specific cultural groups. These groups may be able to provide information, support, advocacy, or assistance in interacting with service providers.

Centers for Independent Living (CIL), Area Agencies on Aging (AAA), and the United Way all provide information regarding services that may exist locally.

5.1 Centers for Independent Living (CIL)

Centers are based in communities throughout Michigan and provide services designed to maximize self-sufficiency and independence of people with disabilities. Services offered may include advocacy, resource and referral information pertaining to housing, transportation, community services and programs, peer counseling, independent living skills training, support groups and recreational events.

Contacting the Office

Local CILs can be located by calling 1 – (888) 255-2457 to obtain the regional office number, or through the local phone book.

Local CILs can also be located by visiting the Capital Area CIL website at http://www.cacil.org/directory.htm. This website gives contact information for CILs operating in the state of Michigan.

Local CIL:

Phone Number: _____

Address: _____

_____

_____

5.2 Area Agencies on Aging (AAA)

AAAs are regional planning, advocacy and administrative agencies. The Michigan Office of Services to the Aging (OSA) contracts with AAAs to plan and provide needed services to qualified persons in specified geographic regions of the state. Many of these services (including respite care) are available to adults of any age. AAAs contract for in-home and community support services for older adults. Through designated state or federal programs, services may be available to younger persons with disabilities.

The Office of Services to the Aging and Area Agencies on Aging operate the MISeniors website, located at http://www.miseniors.net. This website has information on services for the elderly, including nutrition services, housing options, service referral, and health care programs and providers. The website offers a search engine that allows searches for relevant services that are located in communities throughout the state.

Contacting the Office

Contact information for local AAAs is available at the website: www.miseniors.net, by calling the Michigan Office of Services to the Aging (OSA) at 1 - (517) 373-8230, or through the business pages of the telephone book.

Local AAA office:

Phone Number:

Address:

5.3 Long Term Care Ombudsman

The Michigan Long Term Care Ombudsman is a nonprofit program that works with residents, families, and appropriate state and federal agencies to resolve care and safety complaints of residents in adult foster care homes, nursing homes and homes for the aged. Ombudsman staff also assist family members with such issues as resident rights, financial concerns, guardianship and nursing home placement.

Contacting the Office

The Long Term Care Ombudsman for local services may be located by calling toll free at:

1 (866) 485-9393. You may also search for service locations from the Internet at www.miseniors.net (select Search for Services, and select Long Term Care).

Local Long Term Care Ombudsman

Phone Number:

Address:

5.4 Michigan Medicare and Medicaid Assistance Program

The Michigan Medicare and Medicaid Assistance Program (MMAP) is a program that offers free counseling and education to on Medicare and Medicaid benefits. The program is funded by state and federal agencies.

Contacting the Office

MMAP may be contacted through the website www.mimmap.org, or by dialing toll free at:

1 (800) 803-7174.

Local Michigan Medicare and Medicaid Assistance Program

Phone Number:

Address:

5.5 United Way

United Way organizations serve people in their community directly or in collaboration with other local nonprofit organizations. Many United Ways organizations offer a program called "First Call for Help" – a single local telephone number that people in need may call and immediately be referred to the community service(s) that can help them.

Contacting the Office

Local United Way offices can be located in the business pages of the phone book or by calling the Michigan Association of United Ways at (517) 371-4360 or through the website at http://www.uwmich.org/.

Local United Way:

Phone Number:

Address:

APPENDIX I - MEDICAID OVERVIEW

AGENCY POLICY – MA Only

The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. Medicaid is also known as Medical Assistance (MA).

SSI-RELATED AND FIP-RELATED

The Medicaid program is comprised of several sub-programs (i.e., categories). One category is for Family Independence Program (FIP) participants. Another category is for Supplemental Security Income (SSI) participants. There are several other categories for persons not receiving FIP or SSI. However, the eligibility factors for their categories are based on (related to) the eligibility factors in either the FIP or SSI program. Therefore, these categories are referred to as either FIP-related or SSI-related.

To receive MA under an SSI-related category, the person must be age 65 or older blind, disabled, entitled to Medicare or formerly categorized as blind or disabled.

Families with dependent children, caretaker relatives of dependent children, persons under 21 year of age, and pregnant or recently pregnant women receive MA under FIP-related categories.

GROUP 1 AND GROUP 2

In general, the terms Group 1 and Group 2 relate to financial eligibility factors. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. The income limit, which varies by category, is for non-medical needs such as food and shelter. Medical expenses are not used when determining eligibility for FIP-related and SSI-related Group 1 categories.

For Group 2, eligibility is possible even when net income exceeds the income limit. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories.

MA Category	Unique Non-financial Eligibility Factor	Financial Eligibility Group	Automatic MA Eligibility
FIP-related categories:			
Family Independence Program (FIP)	Family with dependent children	1	Yes
Low-income Family MA	Family with dependent children	1	No
Transitional MA	Family with children	1	Yes
Special N/Support	Family with dependent children	1	Yes*
Title IV-E Recipients	Under age 21	1	Yes
Department Wards	Under age 21	1	Yes

* Once established, MA eligibility continues automatically as long as the family remains Michigan residents

** As long as the newborn lives with his mother who is an MA recipient or meets certain MA eligibility factors.

MA Category	Unique Non-financial Eligibility Factor	Financial Eligibility Group	Automatic MA Eligibility
Healthy Kids for Pregnant Women	Pregnant or recently pregnant	1	No
Group 2: Pregnant Women	Pregnant or recently pregnant	2	No
Healthy Kids Under Age 1	Under age 1	1	No
Other Healthy Kids	Under age 19	1	No
Group 2: Persons under Age 21	Under age 21	2	No
Group 2: Caretaker Relatives	Caretaker of dependent child	2	No
Newborns	Newborn	1 or 2	Yes**
SSI-related categories:			
Supplemental Security Income (SSI)	Aged, blind or disabled	1	Yes
Appealing SSI Termination	Appealing SSI termination	1	No
Special Disabled Children	Former SSI recipient child	1	No
503 Persons	Aged, blind or disabled	1	No
COBRA Widow(er)s	Aged, blind or disabled	1	No
Early Widow(er)s	Blind or disabled	1	No
Disabled Adult Children (DAC)	Aged, blind or disabled	1	No
AD-Care	Aged or disabled	1	No
Extended Care	Aged, blind or disabled	1	No
Medicare Savings Programs	Medicare Part A	-	No
Group 2: Aged, Blind and Disabled	Aged, blind or disabled	2	No
Qualified Disabled Working Persons (QDWI)	Type of Medicare	-	No
Home Care Children	Disabled	1	No
Children's Waiver	Disabled	1	No

* Once established, MA eligibility continues automatically as long as the family remains Michigan residents

** As long as the newborn lives with his mother who is an MA recipient or meets certain MA eligibility factors.